EMPOWERING WOMEN FOR SOCIAL DEVELOPMENT IN INDIA: A SOCIOLOGICAL ANALYSIS OF THE WOMEN OF IMPHAL (MANIPUR)

ABSTRACT

THESIS

SUBMITTED FOR THE AWARD OF THE DEGREE OF

Doctor of Philosophy

IN

SOCIOLOGY

BY

THOUNAOJAM SUNITIBALA DEVI

Under the Supervision of

PROF. NOOR MOHAMMAD

DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK
ALIGARH MUSLIM UNIVERSITY
ALIGARH (INDIA)

2008

ABSTRACT

The basic premise of the study is that empowerment of women not only affects health of women themselves, but it also results in greater health benefits to their children, families and ultimately leading to the overall social development of the society. Healthy human beings are central to development because investments in health can translate into healthier men, women, and children and increased capacity to lead socially and economically productive lives. Children who are healthy grow and learn better and have an improved chance of developing the skills necessary for employment. Illness or the death of a household head can lead to family crisis and a vicious cycle of ill-health and poverty.

Manipur is not an exception from the various health problems concerning women. A study on the problems to find solution is the pressing need of the hour. The present study attempts to give a clear sociological outline about the empowerment of women in Manipur in respect to their health particularly reproductive health, within the social, economic and political context of their lives. To meet their health needs, women need to be empowered throughout the evolving stages of a women's life i.e. girl hood, adolescent girls and women. As the health of women is critical in every stage of her life, adolescent girls are also included under this study, as they belong to the initial stage of the reproductive age groups.

Keeping this background in mind, thorough investigation has been carried out with the following objectives:

Objectives of the study:

1. To describe in brief the social, economic, political scenario along with the participation and role played by women.

2. To find out the male-female ratio in Manipur in general and Imphal districts in particular.

3. To asses the educational background of women and available facilities.

4. To asses health needs of women and facilities available to them.

5. To asses and determine the knowledge and awareness about the importance of preventive health check-up, reproductive health, antenatal care, various contraceptive methods and HIV/AIDS etc.

6. To asses and find out the various governmental policies and programmes available for the empowerment of adolescent girls and women in India.

7. To examine how far the adolescent girls in Manipur have been benefited from the policies and programmes.

8. To identify problems and opinions relating to physical and mental development and health concerns of adolescent girls in Manipur.

9. To examine how far women in Manipur have been benefited from the policies and programmes.

10. To asses the decision-making power of the women of Manipur.

Both primary and secondary sources are used extensively in the present study in order to provide an objective empirical support to the study. This study is exploratory-cum-diagnostic in nature. The present study has taken up two districts of Manipur, namely, Imphal East and Imphal West as the area of study. Assessment of the health of women in both the Imphal East and Imphal West districts is done with the help of field surveys. The investigator studied the health and developmental needs of 400 respondents, viz., 100 adolescent girls (11-19

years age group) and 300 women in the reproductive age group (15-49) belonging to different social strata by adopting the multistage stratified random sampling. Separate structured interview schedules are used to collect information from adolescent girls and women respondents.

Findings on adolescent girls:

The findings about adolescent girls in Manipur shows that they need to go a long way to see them as empowered. Discrimination is seen in different forms in case of Manipur also. Preference for sons and discrimination against girls exists in the region, as it does throughout the country. Girls are always expected to help their mother in the household work when only some of respondents' brothers do so. However, one important finding is that no discrimination in terms of education, food, etc. can be seen. They are often found to be regarded a burden on their families and have poor self-image as compared to their brothers.

One finding is that high percentages of girls are aware about the onset of menstruation. Here, mother plays an important role in providing the necessary information. The other sources of information are sisters, friends, and books, etc. The result also shows that those girls who are not given prior information before its onset do suffer from psychological stress, for example, they complained to suffer from discomfort, disgust and are even scared to see blood flow for the first time. This problem if not look into in time may create further health problems to the young girls. Good number of them is found following certain myths that forbid them from taking nutritional food they need to take during menstruation. To add to this, young girls also lack information on hygienic practice during menstruation, which consequently may increase susceptibility to various infections.

Another important factor for psychological stress among adolescent girls is lack of knowledge on physical change that has taken place due to the onset of

puberty. More than half of the girls are unaware and uninformed about the physical changes. But, parents who are regarded as the most important source of information for their children fail to prove. Here, we can see clearly the communication gap between the parents and their children. This deeply affected their interests, their social behaviour and the quality of their affective life, which may deteriorate their health condition and may have long lasting effect.

Further, it is clear from the study that most of the girls in general are aware of the basic knowledge of contraception, pregnancy, and childbirth, RTIs, STIs, and HIV/AIDS, etc. But still a few of them are ignorant that may prove to be risky for their future life, if this need is not addressed properly.

Findings on women:

The findings on Manipuri women reveal many issues relating to their socioeconomic background, their reproductive health needs, level of awareness regarding contraception, decision-making of women, etc. Women in Manipur are found to have low socioeconomic status. Majority is literate but few could go for higher studies. This may be the contributing factor for their lack of decision making power on important matters of sexual life, use of contraception, number of children she wish to have in future, permission in consulting doctors and freedom in mobility, etc.

Important revelations regarding the health status of women shows that majority is health conscious and has awareness regarding contraception, HIV/AIDS, etc. A maximum number of them going for antenatal and post natal care prove it. At the same time, another shocking revelation is that most of them are found to visit doctor only when their illness is serious. Further, it is found that many of them have some gynaecological problems. Women, who lack knowledge indulge in unhygienic practices and beliefs related to menstruation, believes in

certain myths like diseases can be cured by priest or traditional healers and offering to gods and goddesses. So, such women with this belief do not consult doctor. The greatest barrier to their problem is poverty combined with carelessness and lack of knowledge compelling them to various beliefs and practices that may lead to serious health consequences.

The result shows that women in Manipur are not taking part in the development process because of their low socioeconomic status. We can say despite the government policies and programmes, majority of women in Manipur are not empowered and not receiving the health services well. Though some of them are seen having the power, most of the women are not. This affects their health conditions. In the study area, the culture and traditions provide the right and power to male members in the family, to make a decision of the whole things about the women whether male is her father, uncle, brother or husband. The contributing factors that have maintained gender discrimination and the low health status of women in Manipur includes: their low socioeconomic status and situation, differential treatment towards children, insufficient knowledge and lack of awareness regarding their reproductive health, different attitudes and practices relating to health care, and lack of decision making power on important areas that effect their health. Thus, empowerment of women is not possible until and unless women realise their subordinate position and know their values so as to be able to break away from the various restrictions and the dependency that the traditional system of society has to offer.

EMPOWERING WOMEN FOR SOCIAL DEVELOPMENT IN INDIA: A SOCIOLOGICAL ANALYSIS OF THE WOMEN OF IMPHAL (MANIPUR)

THESIS

SUBMITTED FOR THE AWARD OF THE DEGREE OF

Doctor of Philosophy

IN

SOCIOLOGY

BY

THOUNAOJAM SUNITIBALA DEVI

Under the Supervision of

PROF. NOOR MOHAMMAD

DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK
ALIGARH MUSLIM UNIVERSITY
ALIGARH (INDIA)

2008

Dr. Noor Mohammad
M.A. (Eco.), M.A. (Soc.), Ph.D.
PROFESSOR

DEPARTMENT OF SOCIOLOGY
& SOCIAL WORK
ALIGARH MUSLIM UNIVERSITY
ALIGARH – 202002

Date_____

Certificate

This is to certify that ***Miss. Thounaojam Sunitibala Devi*** *has worked under my supervision for her* ***Ph.D.*** *entitled* ***Empowering Women for Social Development in India: A Sociological Analysis of the Women of Imphal (Manipur).*** *She has completed all the necessary requirements prescribed in the academic ordinances and her research work is original and suitable for the submission for the award of the* ***Degree of Ph.D.*** *in Sociology.*

(Prof. Noor Mohammad)
SUPERVISOR

Residence: 4/1294-A, New Sir Syed Nagar, Dodhpur, Aligarh – 202 002

Acknowledgement

First and foremost I wish to thank the Almighty for His kind blessings.

In completing this study, I have received support, guidance and encouragement from several people to each of whom I am indebted and I take this opportunity to express my gratitude to them.

It is my privilege to express my deep sense of gratitude and sincere thanks to my supervisor Prof. Noor Mohammad, Department of Sociology and Social Work, A.M.U., Aligarh, for his excellent guidance and support throughout the period of my study. I had the privilege of having several stimulating discussions with him, which encouraged me to go deeper into the issues of the study. He has been a source of constant inspiration to me. Without his able guidance, I would not have completed this work.

It is my duty to thank the Librarian of the seminar of Department of Sociology and Social Work, A.M.U, Aligarh; Librarian, Maulana Azad Library, A.M.U, Aligarh; Librarian, Manipur University, Librarian, J.N.U, New Delhi; Librarian, I.C.S.S.R., New Delhi. My thanks are due to I.C.S.S.R. and U.G.C, New Delhi for providing me financial assistance during my research.

I wish to express my sincere indebtedness to all the respondents who co-operated with me in collecting the data which forms the basis of this study.

I also wish to acknowledge here and express my gratitude to my parents Th. Kulachandra Singh and Th. Nalini for their kind co-operation and encouragement that I received during the course of this study. My thanks are also due to my brothers and sisters.

Special thanks are due towards my junior Khundrakpam Moirangleima for her loving support and encouragement. I also owe my thanks to my junior Baleshwar Maibam. I also wish to express my sincere thanks to my friends Ranjeeta and Lubna. Finally, it is my senior Kangabam Suraj Singh, who deserves a special word of appreciation and heartfelt thanks for his help in numerous ways in completing this study.

(THOUNAOJAM SUNITIBALA DEVI)

CONTENTS

List of Tables: **Page No.**

List of figures: **Page No.**

CHAPTER I

INTRODUCTION

CHAPTER I
INTRODUCTION

Empowerment of women or women's empowerment has emerged as an important issue in the domain of development in recent times. Scholars, women's groups, social activists and policy makers refer to empowerment as one of their goals. Empowerment is generally seen as the only effective answer to oppression, exploitation, injustice and the other maladies with which a patriarchal society is beset. It is also felt increasingly that women's subordination and exploitation is a result of their powerlessness in patriarchal society, hence the need for women's empowerment.

In the recent past, various international, national conferences and conventions recognise that women need to be empowered for social development. Since then, there is growing awareness among nations that women need to play a significant role in all aspects of development process. The World Bank has suggested that empowerment of women should be a key aspect of all social development programs[1]. The World Bank also reported that empowerment of women is an important policy goal for improving not just the well-being of women themselves but also for its positive impact on the family and society. The concept of empowerment is thus closely related to the concept of social development.

Social development is a process of developing people's welfare. It aims at producing a social well-being that makes people capable of acting and making their own decisions in the broadest sense. To achieve the goal of social development, women need to be empowered so that they have freedom of choice, equal access to domestic and community resources, opportunities and powers. Further, if women are empowered, they can realise their full potential and voiced their concern over their health and development needs. Such conditions have

consequences not only for the women themselves but also for the well-being of their children, the functioning of households and the distribution of resources and the society as a whole. Many researchers have argued that women's empowerment is closely linked to positive outcomes for families and societies[2].

Manipur is not an exception from the various health problems concerning women. A study on the problems to find solution is the pressing need of the hour. The present study attempts to give a clear sociological outline about the empowerment of women in Manipur in respect to their health particularly reproductive health, within the social, economic and political context of their lives. To meet their health needs, women need to be empowered throughout the evolving stages of a women's life i.e., girl hood, adolescent girls and women. As the health of women is critical in every stage of her life, adolescent girls are also included under this study, as they belong to the initial stage of the reproductive age groups.

Conceptual framework

Empowerment means having the capacity to make decisions and gain control over one's own live and the society. The term empowerment has three important components: multidimensional, social and a process. It is multidimensional because it occurs within sociological, psychological, economic, and other dimensions. Empowerment may occur at individual, group, and community level. Further, empowerment is a social process, since it occurs in relationship to others. To add, empowerment is a process that it leads to a path of development. Other aspects of empowerment may vary according to the specific context and people involved, but these remain constant. Empowerment of women would mean the process of improving the condition of women from a state of powerlessness to that of decision making power for themselves, their children and the society as a whole.

Empowered women who are well informed, enjoy good health, and understand the wonderful capacity of their bodies can respect and care for themselves and better care for their families. Women's contributions to the society increase, in direct proportion to their health and level of self respect and self esteem. Well-informed women will get access to healthier and safer pregnancies and births and develop a better sense of themselves as strong and able, and more capable of speaking for themselves with the capacity to better shape their life experiences. They will also make better choices and have access to better health care services. Thus, empowered women may have freedom to shape their lives, their control over resources, their access to basic facilities, their level of political participation, their ability to take their own decisions and get them accepted by family and society and their ability to remove hindrances in their path to progress. What women think and how they feel about themselves, including their personal satisfaction and fulfillments have importance in the empowerment of women in the society for any development.

Empowerment of women has been recognised through many international, national and regional conferences as a basic human right and also as an imperative for national development, population stabilisation and global well-being. Thus empowerment of women is an essential key for social development. The International Conference on Population and Development (ICPD), 1994 and the Fourth World Conference on Women (FWCD), 1995 have given higher emphasis on health issues particularly reproductive health and reaffirmed that it is an indispensable part of women's empowerment and for enhancing their quality of life. It is also recognised that empowering women and improving their status in respect of education, health and economic opportunity is a highly important end in itself that will enhance their decision-making capacity in all spheres of life and especially in the area of reproduction, as reproductive rights are the basic rights for all couples and individuals.

Social development is a process to achieve and integrate a balanced and unified social and economic development of the society that gives expression to the value of human dignity, equality and social justice. It aims at holistic development of human beings, i.e., human development. While income and economic growth are necessary conditions for improving quality of people's lives, they are not always sufficient. Social development is about freedom of expression, participation, decision-making and freedom to work without social bondage. Social development also requires equality of opportunity such as equal access to economic, social, political and cultural opportunities to all citizens. Social development aims at holistic development of human beings that is human development. The Human Development Report 1990, states that people are the real wealth of a nation and the basic objective of development is to create an enabling environment for people to enjoy long, healthy and creative lives.

According to Bilance[3], 'Social development is the promotion of a sustainable society that is worthy of human dignity by empowering marginalised groups, women and men, to undertake their own development, to improve their social and economic position and to acquire their rightful place in society.....'.

James Midgley[4] has had a decisive impact on the international discussion on social development. To him social development is a 'process of planned social change designed to promote the well-being of the population as a whole in conjunction with a dynamic process of economic development'. The goal of social development in the context of modern welfare is to produce a social well-being that makes people capable of acting and making their own decisions in the broadest sense.

Social development first attracted widespread attention through the principles set out in the millennium goals of the United Nations in 1995 (the Copenhagen Declaration –'World Summit for Social Development'). It recognised that social development is central to the needs and aspiration of the people

throughout the world, and to the responsibility of the government and all sector of the civil society. The summit proposed a renewed conception of social development and made the world understand its great significance. It provided an opportunity for rethinking on development goals and strategies amenable and conductive to the promotion of social well being[5].

There is growing realisation to view women's health in a holistic way within the social, economic and educational context of their lives. The Human Development Index[6] covers three dimensions of human welfare such as income, education and health. Loses in human welfare is linked to life expectancy for example woman's poor health can constrain economic growth and performance in education, and slow growth reduces the resources available for social investment.

The various United Nations conferences and conventions also brought India's attention to the issue of women's health problems. For empowering women, the Government of India has ratified various global conferences and conventions such as the International Conference on Population and Development, 1994; the Fourth World Convention on the Right of Child, 1990 etc. This can be seen in the Government's efforts of looking at women's health within a life-cycle perspective in the Tenth Five Year Plan. Further, the Government of India has made several commitments by way of constitutional provisions, legislations, policies and programmes to bring women to the center stage of development planning. The principle of gender equality is enshrined in the Indian constitution in its Preamble, Fundamental Rights, Fundamental Duties and Directive Principles.

Concerning empowerment of women as agents of social development, various measures that have been undertaken by the government of India proved to have considerable progress in social and economic development. The following several health-related aspects do show considerable improvement in the case of women. A reduction in the total fertility rate from 3.4 in 1990-2 to 2.9 in 1996-8,

and an increase in the contraceptive prevalence rate from 41 per cent to 48 per cent, mostly due to increase in female sterilisation[7]. However the disparity in fertility reduction is seen between different regions. In 1951, an Indian woman could expect to live no longer than 32 years; this figure has increase to 65 years in 1996-2001. According to the National Family Health Survey[8] (I, II, III); a reduction of the maternal mortality rate from 468 per 1000 live births in 1980 to 424 in 1992-3 can be seen but it is still high. In the field of education, there is a considerable improvement in female literacy as it come up to the present rate of 39.19 per cent from 8.9 per cent in 1951.

Thus, the data shows that the situation of women has improved to some extent. From this it can be said that women can be active participants in the process of social development if they are provided the necessary health and developmental needs.

However, there still exists a wide gap between the goals enunciated in the constitution, legislation, policies, plans, programme and related mechanisms on the one hand and situational reality of women's status and women's health particularly reproductive health. Thus, women who constitute about half of the total Indian population are not contributing to development because they are always trapped in a cycle of ill health exacerbated by childbearing and hard physical labour. In India, women's poor health status is bound up with social, cultural and economic factors. So, cultural, social and economic barriers can delay or prevent women from seeking reproductive health care at any stage either ante-natal delivery or post-natal. Again, women as a part of the social system are meted with various types of inequalities, which give a raw deal in the society. The male dominated patriarchal system of Indian society gave women the subordinate status where she has been living under the control of first their fathers, then their husbands and finally their sons. Thus in a society like India, where there is inequality between men and women; preference for sons; poor nutrition and health

care in childhood; lack of decision-making power; early marriage; lack of knowledge on reproductive health; contraception; family size and poor state of pre-natal and post-natal and maternal health care services, etc deepens women's health problems.

Adolescents are tomorrow's adult population and their health and well-being are crucial. Yet, the focus on the health of adolescents is relatively recent. According to a report of WHO 2005[9], adolescence can be divided into three developmental stages based on physiological, psychological and social changes. This period of adolescence is different from childhood and adulthood because it is a time of rapid physical and psychological (cognitive and emotional) growth and development, a time in which new capacities are developed, a time of changing social relationships, a time of different needs, changing needs, changing social relationships, expectations, roles and responsibilities. Thus, lack of awareness on their health care, reproductive health, sexual activity and substance use leads to a risky future health condition such as too early pregnancy, risks to mother, risks to baby, health problems during pregnancy & child birth (including unsafe abortion), Sexually Transmitted Infections including HIV/AIDS, mental health problems and so on .

In the context of the above mentioned discussion on women, this study tries to understand the change that women undergo in becoming empowered. It is worth to look at two sets of literature. In the first set of literature, a review of what is empowerment in general, and in the second set of literature, review of what is understood as women's empowerment is discussed. Further, empirical studies done on women's empowerment and its link to their health outcome are also presented.

To clearly understand women's empowerment, one must begin to build an understanding of what empowerment means. Although the notion of women's empowerment has long been legitimised by international development agencies,

what actually comprises empowerment, and how it is measured, is debated in the development literature. The study does not attempt to resolve this debate, but to examine how women's empowerment and its contributing factors that affects their reproductive health needs and health care services. Empowerment in general and women's empowerment in particular is defined differently by different people in different contexts.

Narayan have converged upon a common conceptual framework for understanding empowerment, first outlined in the World Bank publication Empowerment and Poverty: A Sourcebook. Empowerment is viewed broadly as increasing poor people's freedom of choice and action to shape their own lives. It is the process of enhancing an individual's or group's capacity to make effective choices, that is, to make choices and then to transform those choices into desired actions and outcomes[10]. Narayan[11] emphasise on the importance of having a clear definition of the concept of empowerment and the need to specify a framework that shows the linkages between empowerment and improved development outcomes and which indicates determinants of empowerment itself. According to her, empowerment is the expansion of freedom of choice and action to shape one's life which implies control over resources and decisions.

Further, Narayan outlines a conceptual framework containing four building blocks which will be necessary in understanding the main underlying factors that facilitate or constrain poor people's efforts in improving their own well-being leading to broader development outcomes. The four building blocks are: institutional climate, social and political structures, poor people's individual assets and capabilities, and poor people's collective assets and capabilities. All these four components are related to each other and if put together can lead to development outcomes. Out of these four components, the first two building blocks constitute the opportunity structure that poor people face, while the second two make up the capacity for agency of poor people themselves. The opportunity structure of a

society is defined by the broader institutional, social, and political context of formal and informal rules and norms within which actors pursue their interests. Agency is defined by the capacity of actors to take purposeful action, a function of both individual and collective assets and capabilities.

Malhotra and Schuler, also provide an excellent review of this debate. They review the many ways that empowerment can be measured and suggest that researchers pay attention to the process in which empowerment occurs. In the view of Malhotra and Schuler[12] 2005, available literature shows wide diversity in the emphases, agenda, and terminology in discussing empowerment i.e., it is always not clear what writers are referring 'to similar or different concepts', when they use terminology such as 'women's empowerment, gender equality female autonomy or women's status'. Malhotra and Schuler give two defining features of the term 'women empowerment' i. e., process and agency. They add that no other concept emphasise on processes of change that is 'towards greater equality, or greater freedom of choice and action'. The second feature 'agency' stress that women themselves are the main agents in the process of change. Unless and until the intervening processes involved women as agents of that change there can be no real empowerment. Malhotra and Schuler also view that most of the literature stress on the importance of resources. Access and control over certain resources makes some groups control over others in the society for example control over material resources, productive resources and human resources and intellectual resources such as knowledge and information and also the capacity to have ideas and think in new ways. However, Malhotra and Schuler refer to resources not as a feature of empowerment per se but, as 'enabling factors' that can foster an empowerment process.

Another definition given by Kabeer[13] serves as good reference point for conceptualising women's empowerment. It contains both the process and agency elements and that distinguishes empowerment from the general concept of power

as exercised by dominant individuals or groups. Empowerment is defined by Kabeer as 'the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them'. According to Kabeer, empowerment cannot be reduced to a single aspect of process or outcome. How women exercise choice and the actual outcomes will depend on the individual. Choices will vary across class, time and space. Moreover, impacts on empowerment perceived by outsiders might not necessarily be those most valued by women themselves.

The scholarly discussion on empowerment has therefore been context driven rather than theory driven according to Andre Beteille[14]. The context is the contradiction between a hierarchical social order and a democratic political system. Indian society has been a traditional society based on caste and gender where there is inequality between different castes and sexes. In the past the deep rooted ideas of purity and pollution governed the social standings of different castes and sexes; men and women were deemed to be of unequal moral worth as were the different 'Varnas' and the social hierarchy was underpinned by a legal order in which privileges and disabilities were carefully modulated according to caste and gender. Now the law has changed; social attitudes have also changed to some extent. However, despite the changes, the disadvantage group that is women and persons of inferior caste continue to suffer. With the passage of time, there is a growing realisation that the social order cannot be transformed quickly by the laws and plans but the focus is on empowerment of the people .It is in this context that the concept of empowerment emerges. Beteille is of the view that empowerment is both a means to an end and an end in itself.

The most conspicuous feature of the term empowerment is that it contains the word power. In fact, the understanding of the term empowerment is not so easy without understanding of the term power. The concept of power adapts differently to different situations. Andre Beteille is of the idea that the sociological conception of

power may be best understood by viewing in opposition to the anarchist and the populist conceptions of it. In the anarchist conception, power itself can be abolished and human life reconstituted in such a way that the exercise of power becomes redundant. While in populist conception, the emphasis is not about abolishing power but on its radical redistribution where all sections of society participation equally in the exercise of power.

Vilfredo Pareto[15] has greatly influenced the sociological discussion of power. Pareto argued the abolition of property would lead to equality but real basis of inequality was not property but power. Max Weber[16], who has had the largest influence on the sociological study of power, defined power as the chance of a man or a number of men to realise their own will in a social action against the resistance of others who are participating in the action. This conception of power includes coercion, domination and manipulation [17]and thus; the power relationship is by nature an asymmetrical relationship[18]. This conception of power may be called the Zero-sum approach to power where the power of one party can be enhanced only by reducing the power of some other party. Empowerment and disempowerment go hand in hand where the empowerment of some sections of society has to be accompanied by the disempowerment of other sections of it. Parsons argued that power might be viewed not simply as what some have over others, but as a resource of the community as a whole, which it may use more or less effectively in the attainment of its goals.

Thus, power is seen as a source of evil, which can be made into a source of everything that is good by being transferred from the wrong to the right hands, from the landlords to the peasants, from men to women etc. It is for this reason that we cannot conceive of empowerment without taking into account the structure of a particular society. Empowerment can be described as a changed from a hierarchical towards a democratic society. The above-mentioned dimensions of power can be simultaneously applied in the case of empowerment of women. The term

empowerment is most widely used in the context of development. It is also conceived as a process that people undergo, which eventually leads to changes.

Various feminist scholars and activists within the context of their own regions define empowerment as the process of challenging existing power relations and of gaining greater control over the sources of power. Thus, empowerment has different meanings to different actors at different levels. Empowerment in its simplest form means the redistribution of power that challenges patriarchal ideology and the male dominance[19].

To broaden the understanding of empowerment, the following are some proposed definitions of empowerment (of communities or individuals, as the case may be).

According to a report of WHO 2008[20], 'Empowerment is both a process as well as an outcome. As a process empowerment helps relatively powerless people. They work together to increase control over events that determine their lives. It gives them freedom of choice and action. Power or control is not granted to them by other agencies, rather they themselves must obtain it... As an outcome, empowerment is the product of redistribution of resources and decision-making authority. It is reflected in the increased sense of self-esteem in the empowered individual or group of individuals'.

Karl feels that empowerment is a word, which is widely used but not properly defined. One important thing to understand here is that no one empowers anyone else but the people themselves through their own efforts achieve true empowerment. Karl says, 'Empowerment is a process and is not, therefore, something that can be given to people'. She further say that, 'the process of empowerment is both individual and collective, since it is through involvement in groups that people most often begin to develop their awareness and the ability to organised to take action and bring about change' [21].

Greatly influenced by Karl's definition of empowerment, Prasad, R.R is of the view that empowerment is a process geared towards participation, greater decision-making and transformative action through awareness and capacity building[22]. Here participation means that people are closely involved in the economic, social, cultural and political process that affects their lives. The United Nations Development Programme (UNDP) identifies four areas of participation such as household participation, economic participation, social and cultural participation and political participation[23]. Since participation can take place in the economic, social, political, and cultural areas, each person necessarily participates in many ways at many levels. Hence, empowerment would increase participation of women in decision-making in all the above-mentioned spheres.

Laishram Suresh is of the opinion that the equitable participation of women in development has to be seen and that society's responsibilities to support their participation have to be defined, so that women can contribute without detriment to their own society for any development or women's movements, and to oppose any social discrimination and injustice and in so doing fully realise their potential[24].

The International Conference on Population and Development (ICPD), 1994 held in Cairo, broke new ground by winning acceptance in the mainstream population policy discourse for a range of new concepts concerning women's health rights and women's empowerment. It is recognised that the empowerment of women is about enabling women to know, have access and assert their reproductive and sexual rights. It is the absence or denial of the rights that deprives them of the autonomy decision-making power and control over resources that are essential to achieving the highest standards of sexual and reproductive health.

From the Guidelines on Women's Empowerment, put out by the United Nations Task Force on ICPD Implementation[25]: 'Women's empowerment has five components: women's sense of self-worth; their right to have and to determine choices; their right to have access to opportunities and resources; their right to

have the power to control their own lives, both within and outside the home; and their ability to influence the direction of social change to create a more just social and economic order, nationally and internationally'.

According to Mira Shiva, 'empowerment of women means that women no matter where they are, are healthy, have enough for their needs, their own survival and that of their family and community, to be able to live with dignity, live and work in safe and caring environment, which allows their growth and holistic development, i.e., physically, emotionally, socially, economically. Women's empowerment means that they can take decisions about their life, their children and family and also contribute to the community decisions, where women's right to personhood, bodily integrity is respected where their reproductive rights, social, economic and political rights are respected, i.e. their work and contribution to the family, society is recognised, where there is no fear of sexual and social violence, where women feel a sense of acceptance and belonging, where their right to their home and to their children as guardians is respected' [26].

To Batliwala[27], women's empowerment is a process, and the outcome of the process, by which women gain control over material and intellectual resources, and challenge the ideology of patriarchy and the gender-based discrimination against women in all the institutions and structures of society. She states that: '... the goals of women's empowerment are to challenge patriarchal ideology (male domination and women's subordination); transform the structures and institutions that reinforce and perpetuate gender discrimination and social inequality (the family, caste, class, religion, educational processes and institutions, the media, health practices and systems, laws and civil codes, political processes, development models, and government institutions); and enable women to gain access to, and control of, both material and informational resources'.

Stromquist[28], in her article on educational empowerment for women, interprets empowerment as a 'socio-political concept that goes beyond formal political

participation and consciousness raising'. She argues that a 'full definition of empowerment must include cognitive, psychological, political and economic components' and she notes that these components are interrelated. She states:

- the cognitive dimension refers to women having an understanding of the conditions and causes of their subordination at the micro and macro levels. It involves making choices that may go against cultural expectations and norms;
- the economic component requires that women have access to, and control over, productive resources, thus ensuring some degree of financial autonomy. However, she notes that changes in the economic balance of power do not necessarily alter traditional gender roles or norms;
- the political element entails that women have the capability to analyse, organise and mobilise for social change; and
- the psychological dimension includes the belief that women can act at personal and societal levels to improve their individual realities and the society in which they live.

In addition to the above, Monkman[29], adopts a fifth component that is a physical element - having control over one's body and sexuality and the ability to protect oneself against sexual violence - to the empowerment process.

Thus, it can be seen that empowerment can be viewed as both a process, and an outcome, a practice of change, of community restructuring from the inside, outwards. Although in many cases facilitated by an outside force, the process begins within and changes with the community, itself. It is a continual process of growth, realisation of self-worth, hope, and action that evolves with the addition of new ideas, new problems, and new faces within the community group.

Several different efforts have been made in recent years to develop comprehensive frameworks delineating the various dimensions along which women can be empowered.

The frequently used Gender Empowerment Measure (GEM) is a composite measure of gender inequality in three key areas: Political participation and decision-making, economic participation and decision-making and power over economic resources[30]. It is an aggregate index for a population and does not measure empowerment on an individual basis. It consists of two dimensions: Economic participation and decision-making (measured by the percentage of female administrators and managers, and professional and technical employees), and political participation and decision-making (measured by the percentage of seats in parliament held by women). However GEM is limited keeping in view the multidimensional nature of women's empowerment.

Many researchers have stressed the importance of considering the empowerment in multiple domains. Some of them have attempted to measure women empowerment with a variety of determinants and dimensions by different methods and techniques. They have also developed separate indices with different variables in their studies.

Malhotra et al., argues that empowerment is a multidimensional concept. Further, reviewing existing frameworks. they explained many ways in which empowerment can be measured with six dimensions: economic, socio-cultural, familial-interpersonal, legal, political and psychological. It cannot be assumed that if a development intervention promotes women's empowerment along a particular dimension that empowerment in other areas will necessarily follow. A number of studies have shown that women may be empowered in one area of life while not in others[31]. Conversely, Mason[32] observes that women in Kumasi, Ghana, are powerful economically (they work as traders, control a large market and hire men to do their bookkeeping), but they are sexually and socially submissive to their husbands in the domestic arena and peripheral to the political process.

According to Handy and Kassam[33], women's empowerment can be measured by factors contributing to each of the following: their personal,

economic, familial, and political empowerment. They also include household and interfamilial relations as they believe is a central locus of women's dis-empowerment in India. And by including the political, they posit that women's empowerment measures should include women's participation in systemic transformation by engaging in political action[34].

Amin, Becker and Bayes[35] split the concept of women's empowerment into three components each measured separately: Inter-spouse consultation index, Individual autonomy indexes and the Authority index. Inter-spouse consultation index seeks to represent the extent to which husbands consult their wives in household affairs; Individual autonomy indexes represents women's self-reported autonomy of physical movement outside the house and in matters of spending money; and the Authority index, reports on actual decision-making power (which is traditionally in the hands of the patriarch of the family).

Hashemi [36] rely on eight indicators for measurement of comparable components of empowerment: mobility, economic security, ability to make a small purchase, ability to make larger purchases, involvement in major decisions, relative freedom from domination by the family, political and legal awareness, and involvement in political campaigning and protests.

Review of literature

Very few studies have attempted to address the issue of women's empowerment concerning women's health especially based on empirical analysis. Here, attempt is made to present some of the literature that follows.

Education and labor force participation are among the most widely used indicator but, Presser[37], 1997 argues that they are only partially associated with empowerment. In the view of Caldwell[38], 'a large number of studies have shown, almost as convincingly as anything can in the social sciences, that a mother's education has an independent, strong, and positive impact on the survival of her

children'. However, in a study conducted by Das Gupta[39] in Punjab suggest that the relative effect of discrimination against daughters is even greater when the mother is educated. So, there is only partial empowerment of women in a strongly gender inequitable culture.

Several other studies show the links between women's education and reduced fertility, decreased rates of infant mortality. In a study, Schultz[40] found that the higher the level of female education, the lower is the desired family size and the greater the success of achieving it. Further, he found that each additional year of mother's schooling cut the expected infant mortality rate by 5–10 percent. Another study highlighted the value of secondary education of girls for reduced fertility and infant mortality. It showed that doubling the proportion of girls educated at the secondary level from 19 percent to 38 percent in 65 low and middle-income countries, holding constant all other variables (including access to family planning and healthcare), would cut the fertility rate from 5.3 children per woman to 3.9 and the infant mortality rate from 81 deaths per 1,000 births to 38[41].

To Sidramshettar[42], in his study of women's health status in Karnataka shows that the poor health status of women is inextricably linked with the socioeconomic and cultural factors. Illiteracy, low education, early age at marriage, rural residence and other cultural factors also constrain women in acquiring available health services.

Studies also show that empowerment may positively affect demand for and/or use of contraceptives. The Al Riyami et al., study reports on analysis of a 2000 National Health Survey for Oman[43]. They measure empowerment using a composite of two indicators: involvement in decision-making in 8 areas and freedom of movement. Empowered women are more likely to use contraception, however, using logistic regression analysis, they find that education and employment are much more important predictors of contraceptive use than empowerment (empowerment becomes insignificant in specifications combining

the three variables). Empowerment emerges as a significant predictor of unmet contraceptive need (though education was a better predictor still). The Govindasamy and Malhotra[44] study focuses on contraceptive use in Egypt and finds that freedom of mobility and influence in non-reproductive dimensions result in higher contraceptive use.

A study by Kishor, 2000[45], shows that women's empowerment affects a child's health. Kishor points out ten empowerment indicators in a study in Egypt, such as financial autonomy, participation in the modern sector, lifetime exposure to employment, sharing of roles and decision-making, family structure amenable to empowerment, equality in marriage, devaluation of women, women's emancipation, marital advantage and traditional marriage. These factors are derived from a combination of direct measures (e.g., decision-making ability, control of earnings) and indirect measures (education, time worked, and possession of a bank account). In operationalising empowerment, she is careful to include three elements: the setting of women's lives, women's access to potential sources of empowerment and evidence of empowerment. She finds that these empowerment measures, notably women's lifetime exposure to employment, and family structure (denoting past & present residence with in-laws etc.), are negatively associated with infant mortality and positively associated with the probability of complete immunisation of young children.

However, Allendorf's, 2007[46] study presents a counterpoint. She finds that land ownership increases female empowerment and also child nutrition, she concludes that empowerment is not the mechanism through which this link occurs.

According to some scholars, Kishor and Bathliwala, the measurement of women's empowerment needs to take on the current reality of their lives into consideration, their control over 'material assets, intellectual resources, and ideology'.[47]

Scholars argue that in traditional societies such as India, the focus should be on the building blocks, the process, of empowerment, rather than just the end result of empowerment. Thus, indicators of women's empowerment as end-result need to directly measure women's control over their lives and environment[48].

Financial autonomy, or 'control over material assets' according to Bathliwala[49] 1994, has varying effects on both child health outcomes. Women who are allowed to keep money aside for their own (future) use, which is a possible reflection of their autonomy and relatively higher bargaining power within the household, have better-nourished offspring, a result that remains robust with the addition of socioeconomic and other controls[50]. This could be partially ascribed to the fact that women, rather than men, tend to spend a higher share of their earnings/savings on child welfare (such as health, education, etc).

Other indicators of empowerment that have a positive effect on their health include women's access to the mass media (weekly exposure to newspapers, television, and radio) and the freedom to leave the confines of their home to visit the market or friends/relatives without asking for permission from the in-laws. Woman's marriage and household structure (spousal relationship, acceptance of wife-beating, and presence of a mother-in-law) is critical dimension of her ability to enhance the survival of her child.[51]

Hierarchies based on gender and generation determines the course of household decision making in many societies. According to Visaria[52] 1993, women in her sample in Gujarat, India indicate a remarkable feeling of constraint regarding cash expenditure. About 50 per cent of the women do not feel free to take a sick child to doctor without the approval of their husband or parent-in-law, and about 70 per cent do not make decisions regarding the purchase of their own or their children's clothing.

There is an extensive body of research that shows that women are more likely than men to spend the income that they control on food, education, and

health care for their children.

Hindin, 2000[53] constructs a measure of empowerment that considers first whether a woman takes decisions with respect to major household purchases, whether she should work outside the home and the number of children she has – and second, whether she has a say in any of these three decisions. It was found that there is a link between a lack of empowerment with chronic energy deficiency (CED) and a low body mass index (BMI). Having no say in any of the decisions negatively affects these indicators while sole control of the husband has particularly acute effects: women's BMI were 10 percent less and they were 1.3 times more likely to have CED, with implications for their ability to care for themselves and others.

To sum up, empirical evidence of the effects of empowerment is very sparse, but suggests some tentative positive effects of empowerment on outcomes related to the health of empowered women. There is thus a need for further work on this issue, both to identify potential linkages, quantify the effects of empowerment versus other factors, and to elaborate upon the conditions under which empowerment does and does not translate into particular outcomes.

Empirical studies have established that women's empowerment is multi-dimensional, which do not necessarily evolve simultaneously and so measurement schemes should go beyond single indicators. It is also clear that empirical analysis of women's empowerment stress heavily on the individual and household levels to gender relations. Various studies conclude that enabling factors such as education, employment, positive marriage or kinship conditions, lead to women having more choice, options, control, or power over their life conditions. Some other similar studies also conclude that women's control of assets, income, household decision-making etc., yields positive results for themselves, their families, improved child well-being and reduced fertility rates. The variety of definitions regarding the concept of empowerment also shows that it varies from region to region and

culture to culture, so its determinants and measuring methods must also be varied.

Drawing on from many of the authors mentioned earlier, this study attempt to examine women's empowerment more fully and in the broadest sense, using the following dimensions that affect women's health: socio-economic, familial, psychological, practice of family planning, involvement in major decisions, spousal communication, etc. No study of this nature in Manipur more particularly on women's health was carried out on the adolescent girls and women of Manipur, so this study tries to fill this gap.

Objectives of the study

1. To describe in brief the social, economic, political scenario along with the participation and role played by women.
2. To find out the male-female ratio in Manipur in general and Imphal districts in particular.
3. To asses the educational background of women and available facilities.
4. To asses health needs of women and facilities available to them.
5. To asses and determine the knowledge and awareness about the importance of preventive health check-up, reproductive health, antenatal care, various contraceptive methods and HIV/AIDS etc.
6. To asses and find out the various governmental policies and programmes available for the empowerment of adolescent girls and women in India.
7. To examine how far the adolescent girls in Manipur have been benefited from the policies and programmes.
8. To identify problems and opinions relating to physical and mental development and health concerns of adolescent girls in Manipur.

9. To examine how far women in Manipur have been benefited from the policies and programmes.

10. To asses the decision-making power of the women of Manipur.

Hypotheses

In order to achieve the above-mentioned objectives, the present study is directed to test the following hypotheses:

1. Women of Manipur are empowered right from adolescence period.

2. Women of Manipur are empowered till their last breath in socio-economic spheres.

3. Women of Manipur due to lack of awareness have different attitudes and practices regarding health which caused imbalance into the sex ratio.

4. Manipuri women are having knowledge of contraceptive methods but its use is low due to their concern about possible side effects.

5. Manipuri women who are economically independent are able to have their partners of their choice and are free to decide on the number of children they want.

6. Manipuri women are well aware about the illness of HIV/AIDS but knowledge to avoid it is low.

7. Majority of women in Manipur are not aware of the women oriented governmental programmes and hence fail to benefit from such programmes.

Research Design

The present study is exploratory-cum-diagnostic in nature. Various information relating to women's empowerment in Manipur have been explored by going through the secondary sources viz., Statistical Records (1995-2006) published by the Directorate of Statistics and Economics, Government of Manipur (GOM); Directorate of Census Operation (GOM), Election Department (GOM), Department of Information and Public Relations (GOM), Social Welfare and Family Welfare (GOM) etc. Apart of these, various relevant books and articles kept in the libraries of Manipur University, Manipur; Jawaharlal Nehru University, Delhi; Indian Council of Social Science Research, New Delhi and Maulana Azad Library, Aligarh Muslim University, Aligarh have been thoroughly examined and explored. Primary information (data) has been collected from the field by the help of Interview Schedule.

Methodology

Field data relating to the area of study has been collected by the help of structured interview schedule. The structured interview schedule is developed with the help of questionnaire used in similar studies like National Family Health Survey, District Level Health Survey. Simultaneously discussions with government officials, NGOs, local clubs are also carried out in order to include relevant questions to be explored. Two separate structured interview schedules were prepared – one for the adolescent girls and the other for the women to collect information separately. The Structured Interview Schedule consisted of independent and dependent variables such as age, religion, educational background, economic status, marital status, awareness regarding physical changes occurred in their bodies and use of facilities provided by the government through various programmes launched from time to time relating to use of contraceptives, fertility preferences and decision making etc.

Selection of Universe:

Selection of universe in terms of area and in terms of the respondents has been done by adopting multistage random sampling. In terms of an area, Manipur state has been selected for the purpose of study.

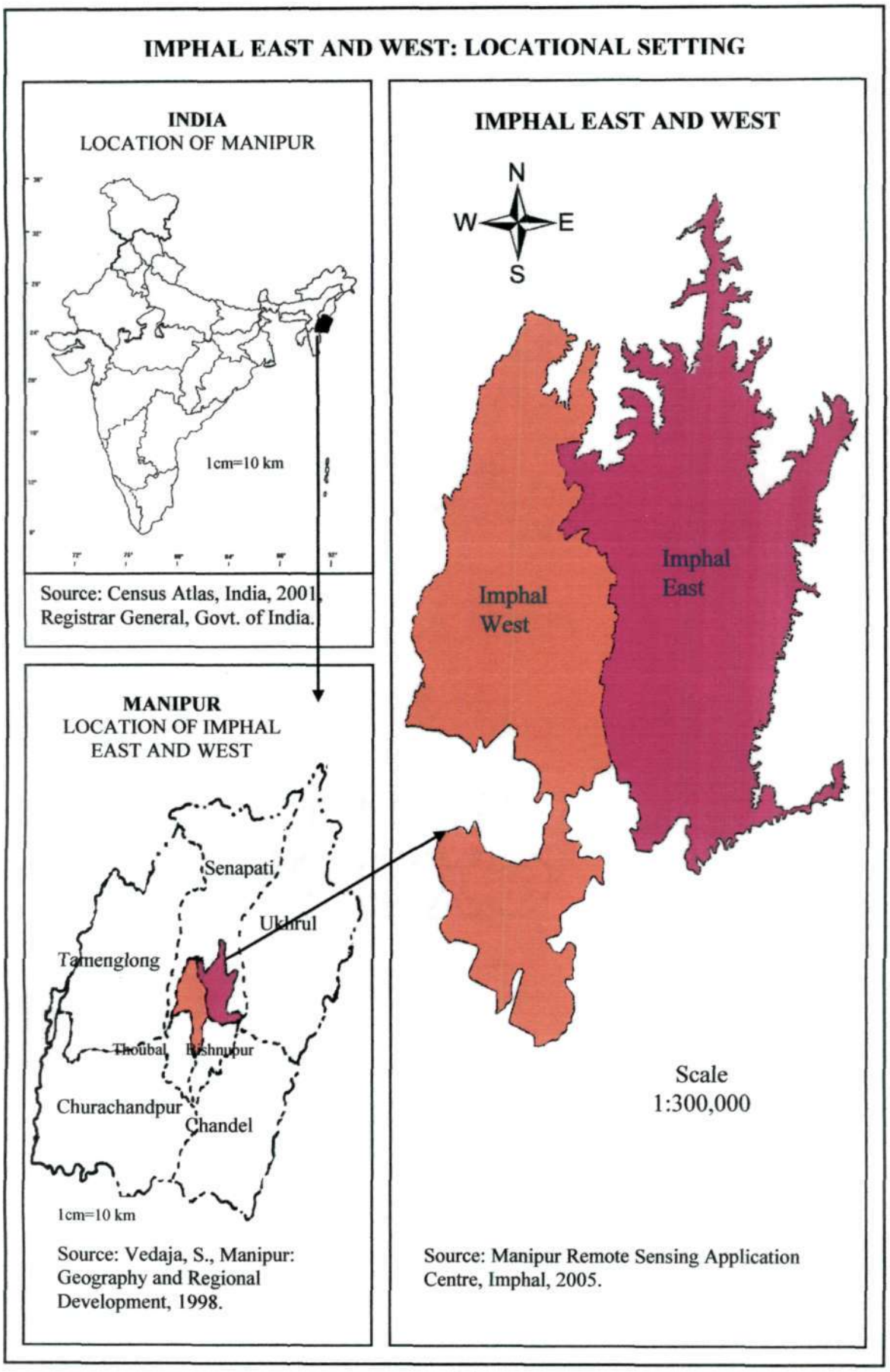
General Background of the Study Area

Manipur (93^0 $03^/$ to 94^0 $47^/$ east longitudes and 23^0 $50^/$ to 25^0 $41^/$ north latitudes) is an isolated hill grit state lying in the extreme North-eastern corner of India along the Indo-Myanmar border with Imphal as the state capital. The total geographical area of the state is 22,327sq.km with a total population of 23, 88,634 (Males: 1,207,338; Female: 1,181,296 in 2001 Census). It could be broadly divided into two the hilly region and the valley region. The state comprises of districts of which five districts namely Churachandpur, Tamenglong, Ukhrul, Senapati and Chandel lies in the hilly region while remaining four namely, Imphal East, Imphal West. Thoubal and Bishnupur falls in the valley region. Manipur consists of fertile, oval shaped valley in the centre surrounded on all sides by hills. About 90 per cent of the state is mountainous and the rest of it is shared by the lacustrine plain of central or Imphal valley.

As per 2001 census, the sex ratio in Manipur is 978 of every 1,000 males. The literacy rate is 68.87 percent and male percentage is 77.87 where as female is 59.70 per cent.

The present study area, Imphal is the capital city of Manipur. It covered an area of 1,228 square kilometer. It covered nearly 50 per cent of the valley area of the state. The district Imphal was divided into Imphal East district and Imphal West district in 1997 (Fig. 1.1).

Figure: 1.1


IMPHAL EAST AND WEST: LOCATIONAL SETTING
INDIA
LOCATION OF MANIPUR
1cm=10 km
Source: Census Atlas, India, 2001, Registrar General, Govt. of India.
MANIPUR
LOCATION OF IMPHAL EAST AND WEST
Senapati
Ukhrul
Tamenglong
Thoubal
Bishnupur
Churachandpur
Chandel
1cm=10 km
Source: Vedaja, S., Manipur: Geography and Regional Development, 1998.
IMPHAL EAST AND WEST
N
W
E
S
Imphal West
Imphal East
Scale
1:300,000
Source: Manipur Remote Sensing Application Centre, Imphal, 2005.

The Imphal East district is situated in two separate valleys of the state namely central valley and Jiribam valley. The total area of district is 670 sq.km. As per 2001 census, the population of district is 394876, of which male population is 198371 whereas female population is 196505. The sex ratio of Imphal East is 991 females per thousand males. The literacy rate is 75.4 per cent, and male percentage is 85.5 per cent and that of females is 65.3 per cent.

Imphal West district falls in the category of Manipur valley region. The district is surrounded by Senapati district on the North, on the East by Imphal East and Thoubal district, on the South by Thoubal and Bishnupur district and on the West by Senapati and Bishnupur district. The total area of the district is 558sq.km. The population of the district is 444383, of which male population is 221781 and total female population is 222601. The sex ratio is 1004 females per thousand males. The literacy rate is 80.2 per cent of which male percentage is 89.2 per cent and that of female is 71.3 per cent.

Being an isolated hill state, Manipur has a distinct type of population, culture, life style, ritual practices, social taboos, more etc. Manipur is composed of four major groups, the Meitei, the Tribals, the Muslims and the non-Manipuris (Singh, R.L., 1971; Singh, T.V., 1975; Singh, R.P., 1982). *Meitei* constitute the largest ethnic groups of the region. The *Meitei* language or *Meiteilon* is the mother tongue of all Manipuri.

Sampling Design:

Manipur state is located in the hilly track of the NEFA region. It is divided into nine districts. Out of these nine districts, two districts i.e., Imphal East and Imphal West have been selected randomly for the purpose of study. Both the districts have four sub-divisions each. Imphal East has four sub-divisions namely Jiribam, Sawombung, Porompat and Keirao Bitra. From these four sub-divisions Sawombung and Porompat sub-division are selected. Again, under Sawombung

and porompat sub-divisions, eight areas are selected for the study, out of which four are Urban (U) and four rural (R). The eight selected areas are namely Lamlai (U), Pangei (R), Taretkhul(R), Pungdongbam(R), Porompat(U), Khurai Thoudam Leikai(U), Khurai Sajor Leikai(U) and Ragailong(U).

The same selection is done in case of Imphal West also. Imphal West has four sub-divisions viz., Lamshang, Patsoi, Lamphelpat and Wangoi. The Lamphelpat and Wangoi sub-division is selected, from which eight areas both rural and urban are selected namely, Thangmeiban(U), Sagolband(U), Keishampat(U), Heinoukhongnembi(U), Samurou(U), Hiyangthang(R), Mongsangei (R) and Sangaiporou mamang(R).

So altogether sixteen areas, eight each from both rural and urban are selected from Imphal East and Imphal West districts. From these above-mentioned sixteen areas 100 adolescent girls (age group 10-19 years), 50 each from Imphal East and Imphal West are selected. In the same way 300 women (reproductive age group 15-45 years), 150 each from Imphal East and Imphal West are selected for sampling. The total sample size consisted of 400 women viz., 100 adolescent girls and 300 women. The mentioned 400 women are selected as respondents randomly using the simple multi-stage stratified random sampling.

Data Collection and Analysis:

Two-year time is spent in data collection. The selected respondents are interviewed personally by the researcher on the basis of Structured Interview Schedule. To make an in-depth study, the researcher secured co-operation from the respondents by giving a brief statement the reason for conducting the study. The confidential nature of the study is also explained. The interview is done at their household and researcher visited at least twice to cross checks the information provided. After completing the investigation, the processing of the

data and the task of analysis is done. The interview schedule is checked and errors are found to be few. The data collected from 400 respondents is then tabulated and entered in spreadsheet and using computer. Simple percentages have also been calculated for easy understanding of the data.

Chapterisation

The present study is organised into five chapters. The first Chapter I presents a review of studies on women's empowerment and provide the objectives and methodological details of the study. The following Chapter II provides a review of the past and present status of women in India and Manipur and also the various available government Policies and Programmes meant for adolescent girls and women. Chapter III presents a discussion of the data gathered from adolescent girls relating to their awareness and attitudes regarding reproductive health. Chapter IV also presents a discussion of the data collected from women relating to empowerment and its effects on their health and society. The last and the final Chapter V summarise the findings of the study and draw the conclusions.

References

[1] World Bank, (2001), Engendering Development: Through Gender Equality in Rights, Resources, and Voice. World Bank Policy Research Report, Oxford: Oxford University Press.

[2] Presser, H. and G. Sen, (2000), Women's empowerment and demographic processes: Moving beyond Cairo, New York: Oxford University Press.

[3] Bilance, (1997), A world in balance – Bilance stands for Social Development: Policy paper, Oegstgeest, September.

[4] Midgley, J, (1995), Social development: The developmental perspective in social welfare. Thousand Oaks, CA: Sage.

[5] Srivastva, S.P. (1998), (ed.), Development Debate: Critical Perspective, Jaipur: Rawat Publications, p. 74.

[6] Human Development Report, (2005), Oxford University Press, New Delhi, Published for the United Nations Development Programme (UNDP).

[7] Raju, S., (2007), India Social Development Report, Council for Social Development, Oxford University Press.

[8] IIPS, (2000), National Family Health Survey, India 1998-99. IIPS, Mumbai.

[9] WHO, (2005), Nutrition in adolescence –Issues and Challenges for the Health Sector, Issues in Adolescent Health and Development. (WHO discussion papers on adolescence). http://whqlibdoc.who.int/publications/2005/9241593660_eng.pdf

[10] Alsop, R., Bertelsen, M. and Holland, J. (2006) Empowerment in Practice: From Analysis to Implementation, p.10, Washington. D.C., World Bank.

[11] Narayan, D, (2005), Measuring Empowerment: Cross-Disciplinary Perspectives, Washington DC: World Bank.

[12] Malhotra, A and S Schuler, (2005), Women's Empowerment as a Variable in International Development, In Measuring Empowerment: Cross-Disciplinary Perspectives. 71–88. Narayan, D, (ed.), Washington DC: World Bank, Gender and Development Group.

[13] Kabeer, N, (2001), Reflections on the Measurement of Women's Empowerment- Theory and Practice, in: Discussing women's empowerment-theory and practice, Stockholm, Novum Grafiska AB.

[14] Betteile, Andre, (1999), Empowerment, Economic and Political Weekly, March 6-13.

[15] Pareto, V, (1926), Les Systems Socialistes, Marcel Giard, Paris, 2 vols.

[16] Weber, M, (1978), Economy and Society, University of California Press, Berkeley.

[17] .Shills, E, (1975), Centre and Periphery, University of Chicago Press, Chicago.

[18] Betteile, Andre, (1999), op. cit.

[19] Chandra, Shanti Kohli, (1997), Women and Empowerment, Indian Journal of Public Administration, July-September, Vol.XLIII. No.3.

[20] WHO, (2008), Tackling Social and Economic Determinants of Health through Women Empowerment, The SEWA Case Study. New Delhi, WHO.

[21] Karl, Marilee, (1995), Women and Empowerment: Participation and Decision Making, Zed Books Ltd. London and New Jersey.

[22] Prasad, R.R, (2004), 'Participation and empowerment: Rhetoric and reality' in 'Rural Development through Women's participation and electronic Media' (Ed) Sawalia Bihari Verma, Shiv kumar Singh, Pointer Publishers, Jaipur.

[23] UNDP, 1993, Human Development Report, New York, Oxford University Press, pp 21- 22.

[24] Laishram, Suresh, (2002), Health and the Status of Women in Manipur, Seminar on Manipur Women's Movement in the 20th cent. 26th and 27th March, 2002, Courtesy: The Imphal Free Press.

[25] United Nations Population Information Network, Guidelines on Women's Empowerment, http://www.un.org/popin/unfpa/taskforce/guide/iatfwemp.gdl.html

[26] Mira Shiva, (2001), Health Care in Last 50 years and Women's Empowerment, in Empowering the Indian Women, (Ed) Promilla Kapur, Publications Division, Ministry of Information and Broadcasting, Government of India.

[27] Bathliwala, Srilatha, (1994), The Meaning of Women's Empowerment: New Concepts from Action, In Population Policies Reconsidered: Health, Empowerment, and Rights, Gita Sen, Adrienne Germain, and Lincoln Chen (ed.), Cambridge, MA: Harvard University Press.

[28] Stromquist, Nelly P. (1995), The Theoretical and Practical Bases for Empowerment, In Carolyn Medel-Anonuevo (ed.) Women, Education and Empowerment: Pathways Towards Autonomy, Report of the International Seminar held at UIE, Hamburg, 27 January – 2 February 1993. Paris: UNESCO.

[29] Monkman, Karen, (1997), Training Women for Change and Empowerment, in Nelly Stromquist (ed.) Women in the Third World. Garland.

[30] UNDP, (1993), Human Development Report, New York, Oxford University Press, pp 21- 22.

[31] Malhotra, A. and M. Mather., (1997), Do Schooling and Work Empower Women in Developing Countries? Gender and Domestic Decisions in Sri Lanka, Sociological Forum 12(4), p. 599-630.

[32] Mason, K. O, (2005), Measuring Women's Empowerment: Learning from Cross-National Research." P. 89-102 in Measuring Empowerment: Cross-Disciplinary Perspectives, Deepa Narayan (ed.) Washington, D.C.: The World Bank.

[33] Femida Handy and Meenaz Kassam, (2004), Women's empowerment in rural India, Paper presented as the ISTR conference, Toronto Canada

[34] Bathliwala, Srilatha, (1994), op. cit.

[35] Amin Rahul, Becker Stan and Byes Abdul, (1998), NGO-Promoted Micro credit Programs and Women's Empowerment in Rural Bangladesh: Quantitative and Qualitative Evidence, The Journal of Developing Areas, Winter, 221-236.

[36] Hashemi Syed, Sydney Ruth Schuler and Ann Riley, (1996), Rural Credit Programs and Women's Empowerment in Bangladesh, World Development, Volume 24, No. 4: 635-653.

[37] Presser. H, (1997), Demography, Feminism and the Science-Policy Nexus, Population and Development Review 23: 295-333

[38] Caldwell J. C. and P. Caldwell, (1993), Women's Position and Child Mortality and Morbidity in Less Developed Countries, Pp. 122-139 in Women's Position and Demographic Change, edited by N. Federici. K. O. Mason, and S. Sogner. Oxford: Clarendon Press.

[39] Dasgupta, Monica, (1987), Selective Discrimination against Female Children in Rural Punjab, India, Population and Development Review 13(1): 77-100.

[40] Schultz, TP, (1993), Returns to women's schooling, In Women's Education in Developing Countries: Barriers, Benefits and Policy, Hill, EKaMA, (ed.) Baltimore: Johns Hopkins University Press.

[41] Subbarao, Kalr, (1995), Social gains from female education, Economic Development and Cultural Change, 44(1).

[42] Sidramshettar, S. C (2004), The Journal of Family Welfare, Vol. 59, No. 2, December 48-54.

[43] Al Riyami A.A., M. Afifi and R. Mabry, (2004), Women's empowerment in Oman and its influence on contraceptive use. Reproductive health matters 12:23, p. 144–54.

[44] Govindasamy, P. and A. Malhotra (1996), Women's Position and Family Planning in Egypt, Studies in Family Planning 27 (6): 328-340.

[45] Kishor, S., (2000), Empowerment of Women in Egypt and Links to the Survival and Health of Their Infants, In Women's Empowerment and Demographic Processes: Moving Beyond Cairo. Harriet Presser and Gita Sen, (eds.) New York: Oxford University Press.

[46] Allendorf, K. (2007), Do Women's Land Rights Promote Empowerment and Child Health in Nepal?, World Development 35 (11): 1975-1988.

[47] Kishor, S., 2000, op. cit.

[48] Kishor, S., 2000, op. cit.

[49] Bathliwala, Srilatha, (1994), op. cit.

[50] Jejeebhoy, S.J. (2000), Women's autonomy in rural India: Its dimensions, determinants and the influence of context., In H. Presser and G. Sen (Eds), Women's Empowerment and Demographic Processes: Beyond Cairo, New York: Oxford University Press.

[51] Kishor, S., 2000, op. cit.

[52] Visaria, L, (1993) Female autonomy and fertility behaviour: An exploration of Gujarat data. In Proceedings of International Population Conference of International Union for Scientific Study of Population, Montreal, Vol. 4, Liege, Belgium: IUSSP. 263-275.

[53] Hindin, M. J. (2000), Women's Power and Anthropometric Status in Zimbabwe. Social Science and Medicine 51:1517-1528.

CHAPTER II

STATUS OF WOMEN IN INDIA AND MANIPUR

CHAPTER II

STATUS OF WOMEN IN INDIA AND MANIPUR

This chapter presents a brief historical background of women and the present situation of women's social position in order to have clear idea about the health and developmental needs of adolescent girls and women. Attempt is also made to look in detail, the government of India's effort relating to the health needs of adolescent girls and women.

Women in India: An overview

First, it may be helpful to provide a brief historical perspective on the status of Indian women in general in order to effectively deal with the various problems faced by them. Different sociological perspectives have identified different factors as being responsible for the status or positioning of an individual in any given society. The Indian social system with a few exceptions is characterised by Patriarchy. Patriarchy recognises male dominance and female subordination in the Hindu society. In India, women have always lived dependent lives firstly through their fathers and brothers and later through their husbands and sons.

The traditional roles associated with the home such as cooking, cleaning, washing, caring of children etc are allocated to women thereby rendering a less prominent status in society. Women are expected to play these traditional roles and they continued to do so. As they lived a dependent life, they cannot take decisions independently. Thus, their male counterparts continuously exploited them. Contrary to this, men are required to fulfill their role as the maintainer and the protector of the family. A man's world is outside the home, where he earns his living, interacts in the public sphere, and makes all the important decisions. Women are largely absent from public life. This shows clearly the difference in the status between men and women.

Some early writers are of the view that the low status of women is biologically determined and is a universal and immutable fact. George Peter Murdock, in his cross-cultural survey of 250 societies ranging from hunting and gathering bands to modern nation states give the idea that women, because of her biological function of childbearing and nursing is tied to the home base; because of her physique she is limited to less strenuous tasks such as cooking, gathering wild vegetable products, water carrying and making and repairing clothes etc. While man with his superior physical strength undertake the more strenuous tasks, such as lumbering, mining, quarrying land clearance and house building, etc. Murdock concluded that, "The advantages inherent in a division of labour by sex presumably account for its universality". Social status has been reckoned in terms of the degree to which a person possesses qualities or attributes that are considered valuable in a particular society and performs his role accordingly[1].

To Talcott Parsons, for a family to operate efficiently as a social system, a women's expressive role is essential. This means she provides warmth, security and emotional support for effective socialisation of the young and to her husband with love, consideration and understanding[2].

John Bowlby examines the role of women from a psychological perspective and gives a similar argument like Parsons. Bowlby concludes that it is essential for mental health that the infant and young child should experience warm, intimate and continuous relationship with his mother[3].

Some, who argue that gentler roles are culturally determined and socially transmitted, oppose such view. Ann Oakley[4], a British sociologist and a supporter of the Women's Liberation Movement attack all the above assumptions that biology largely determines that sexual division of labour. She argues that gender roles are culturally rather than biologically determined and is not universal. She regards as a myth the incapacity to carry out heavy and demanding work. Studies from large

number of different societies indicate that the mother role is a cultural construction and children do not require a close, intimate and continuous relationship with her.

Ernestine Friedl[5] supports the cultural explanation and shows that male dominance and gender roles are culturally determined. She observes that in some societies, activities that are regarded, as men's were women's in some other societies for example, weaving, pottery making and tailoring. However, men carry higher prestige than women do. This Friedl sees as a reflection of male dominance, which exists, to some degree in all societies. She opines that men are dominant because they control the exchange of valued goods beyond the family group, which brings prestige and power. The greater their control over the exchange of valued goods outside the family the greater their dominance.

Every society has allocated different statuses to men and women that have resulted in the creation of a social order, which is not only gender unequal but also gender unjust. An attempt has been made to examine the status of women in India during different periods of time, which will provide an insight into different factors that have led to their low status and thus ultimately restricted women (50 per cent of the total population) from the opportunities to take part in the developmental activities of the country.

Not all women in India have a common status. Status is closely affected by considerations of caste, class, religion, and region and so on. The attempt here is not to go into the details of periodisation and its controversies but to provide a general overview. However, it is crucial to have a brief look at the part society, because some of the norms and values affecting women today have their roots in the past.

A women's life has been moulded for ages. In the past the women was a slave and nowadays she has been reduced to the situation of a doll in a showcase. Our women are the frogs in the well, constricted in their conduct by tradition[6]. A review of the past and present is necessary to look into the position or status of women in India.

The Rig Veda, a religious text is the oldest source of information available on the ancient period. Many scholars observed that during the period of the Rig Veda there was near equality between men and women in various areas of social life.

Women have better situation in terms of access to education, religious rights, freedom of movement, etc in the Vedic Period[7]. Woman could marry a man of her own choice. They could also remain unmarried and remain Brahma Vadinis devoted to the pursuit of knowledge and self-realisation. Love marriage was also reported during this period[8]. Marriage was based on truth and duty. During the marriage ceremony, woman promises in the *Saptpadi* (seven steps taken around the fire), that she will look after her husband and his family, and the husband endows her with his wealth, grain and eatables, which are her managerial responsibility. She thus has equal rights as a partner.

The most important role of woman besides being a wife is that of motherhood which was recognised as a fundamental right of a woman. Sons were instructed to respect and care for their mothers. There was no difference between children of different sexes. There was no objection to the birth of girl child instead special mantras had been prescribed for the birth of a girl child. The Rig Veda praises the woman who has undergone the Upanayan ceremony. There is a reference in Rig Veda to a system in which the husband's brother or a close male relative could invite a window from her husband's funeral pyre to marry him. This indicates that widow remarriage was not banned during this period[9].

In the epics, the Ramayana and the Mahabharata, Sita and Draupadi can be mentioned. In the Ramayana, Sita is more often regarded as the ideal Hindu woman who always portrays the character of a self-sacrificing and obedient wife. Sita's accompanying her husband to the forest on her own will clearly shows her loyalty towards her husband. However, in the Mahabharata, we can see Draupadi as the stronger female character, which was not only beautiful and capable but was determined to do the right thing by her to preserve her honour and her dignity. Here

one example can be mentioned when Dushasan on command of Duryodhana, she being well versed in the legal system of the time, appealed to the laws of the lord. The above-mentioned characters are strong women embodying the ideal of chastity who married men of their choice.

The position of women began to decline from the period of Manusmriti, i.e. 500 B.C. to 1800 A.D[10]. The Manav code paid down a pattern of hierarchical caste structure, Patriarchal joint family and the subordinate status for the Shudras and women. Generally, women are treated and equated with the Shudras. Even the Bhagavad Gita places women, Vaishyas and Shudras in one category and describes them all as being of sinful birth.

Out of all, the laws of Manu have influenced women largely. Manu viewed that woman, as a daughter should live under the control of her father as a wife of her husband and as a window of her son. As per the laws of Manu, a devoted wife should serve even a bad and adulterous husband as a God. Women have to preserve her chastity and her responsibility was to manage the household as well as to care every member of the family and guests. In a marital relation, a man had absolute control over his wife. The husband had the right to award punishment to his wife if she committed crimes. She was not expected to remarry after widowhood[11] but is fit for Niyoga i.e. intercourse only with husband's near relatives for begetting children[12]. This was to keep up the line of her husband. The Manusmriti is entirely silent about the widow burning (Sati). The Rama says that the greatest suffering that a woman can have is widowhood. A widow did not receive much sympathy from society. Whether she lived in the family of her husband or separately, she was always look down upon in the society. Her very right was regarded as most inauspicious so was generally treated as an outcaste on festive occasions. The case is hot the same for the husband. He could remarry after the death of wife. The man is also entitled to remarry if the wife cannot beget him a son. It was stated that a woman should never be independent

for she would abuse it. According to Manu, man and woman are unequal in strength, stamina and psychology[13].

The Smriti writerheld that when a girl reached the age of 10, she should be regarded as having attained puberty so her marriage should not be postponed any further. However, for inheritance of property is concerned, woman could inherit property and wealth if unmarried or no male issues of their family were left. Women could also keep their stridhan (money given to them by parents or in-law)[14].

It may be summed up that the entire concept of the Smriti writers was to keep women inferior to men. Throughout her life, a woman did not have a life of her own but was always controlled by somebody else as if she was a commodity. The poor situation of women continues even today in many Indian families.

During the Muslim rule, women of the middle and the lower classes had a tougher time than the princesses, queens and begams of the aristocrats[15]. They were married at young age, have many children and work as domestic servants, singers, and dancers. The Mughal class and middle class women received education whereas the poor remained illiterate. The system of Purdah began to be practiced by all high-class Muslim women as well as Hindus. Even Sati continued to be practiced by the ruling class and higher castes though some rulers banned this custom. However, this practice was rare among the lower classes and castes.

Thus, it appears that early marriage, the Purdah, the Sati, the prohibition of widow remarriage etc., contributed to the degradation in the status of women.

During the British rule, there were political and social movements, which greatly affected the position of women. These were the Social Reform Movement of the 19th century and the Nationalist Movement of the 20th century. Efforts began to be made by the 19th century social reformers to counter the social evils such as Sati, female infanticide, child marriage, ban on widow marriage, denial of access to education and health care which are the real blocks to women's development. The

social reformers laid great stress on the education of women and the enactment of progressive legislation, through which the women's condition will be improved. Due to the efforts of the committed reformers, many laws were enacted which tried to eradicate certain social evils. It was because of the great effort of Raja Ram Mohan Rai (1774-1833) which strengthened the hands of Lord William Bentinck the Governor-General of India at that time, that in 1829 Sati was abolished and made it a crime. Iswarchandra Vidhyasagar (1820-1871) with his untiring efforts made widow remarriage legal with the enactment of the Widow Remarriage Act of 1856. Another credit goes to Keshab Chandra Sen (1838-1884) for the Civil Marriage Act 1872, which was a great landmark of the 19th century. This act made marriage a secular ceremony and provided for the registration of the marriage. It rose the age at marriage of girls to 14 years, made widow remarriage, and inter-caste marriage legal. The most significant feature of the Act was the enforcement of monogamy.

Another attempt of the social reformers is to educate Indian girls and they do succeed in opening few schools for girls. Major impetus came from the Christian missionaries. Because of their efforts, great progress was made in girl's education in the last quarter of the 19th century. By 1902 there were over 256,000 girls in the various institutions and as many as 169 in the liberal arts colleges. Women started entering into the professions of teaching and medicine.

The 20th century Nationalist Movement particularly during the Gandhian phase not only helped in changing the status of women but also the attitude towards women. The Nationalist Movement not only drew a large number of women to political activity but it also generated strength and confidence among women which helped them to organised and to fight for their own cause, rather than depend upon the benevolent men is society to promote their cause. Gandhiji apart from being a political leader, work hard for the equality of women and for their rights. He asserted that woman has the same right of freedom and liberty as man. He vehemently condemned the custom of child marriage, prohibition of widow remarriage,

prostitution and the custom of Purdah. Gandhiji also continuously urged the women to think independently by themselves and make decisions of their own without depending on the male members or blindly following the custom. He showed the importance of the participation of women (who constitute 50 percent of the population) in the developmental activities of the country. Child marriage was banned by an Act of 1929 that the minimum age at marriage was 18 years for girls and 21 years for boys.

After independence, the social, economic and political structures and the cultural milieu are dominated by patriarchal ideology. There has been a differential impact of factors of change in different sections of women, which is hazardous. After independence, we can see a change in the public opinion regarding the education of girls, age at marriage and employment of women specially in the urban areas. There also women who are able to break the traditional barriers and started working in non-traditional jobs and are also holding decision making posts and move freely. Some are of the view that the status of Indian women has improved. In reality, women are still facing numerous problems. In small towns and rural areas, the long hours, women spent in activities of kitchen, bearing and rearing of children, fetching water and bringing firewood etc. is because of the patriarchal system that has confined women to such homebound specific areas, which are unpaid. There are strong differences between the women of urban and rural areas. Women generally are confined to domestic roles, which restricted their mobility and opportunities to benefit equally from the resources of society, which kept them subordinate to men.

Women often internalise their role as natural, thus inflicting an injustice upon them. Bhatia points out that woman still have to take invariably the responsibility of home and family cares, consequently sacrificing their leisure and personal care time. Thus, women in India are still having a very low status in the family as well as the society .The low status of women has an adverse affect on their health condition.

Health and developmental needs of adolescent girls and women

As mentioned before, the health of Indian women is said to be related to the socio-economic status of the households to which they belong and their age and marital status within the household. There is discrimination against girls resulting from son preference, as sons are expected to care for parents in their old age. Further, Indian women have low levels of education, limited power over their own sexual and reproductive lives and lack of influence in decision-making. They have been living under the control of first their fathers, then their husbands, and finally their sons. Women thus starting from their childhood days are less likely to get good care, food and necessary nutrition, excess to health care and education, which later on may have reproductive health consequences.

In India, generally women marry at a very young age with no knowledge of reproductive and sexual health. Poor nutrition leading to anaemia combined with lack of knowledge of reproductive health and family planning services often force women to too many or too closely closed births. This is said to be one of the reason for the high Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR), low-birth weight babies, high fertility rate etc that occurred during the reproductive age of women in India. The Tenth Five Year Plan reported that MMR has been declining from 468 in 1980 to 407 in 1998, which is still very high so it is a matter of great concern[16]. The incidences of MMR, IMR along with educational backwardness of women results in low socio-economic status of women and limit their access to education, good nutrition, family planning and health care services.

All these conditions adversely affect not only the health of women themselves but also the well-being of their children. This is because the health of women plays an important role in determining the health of the future population. Women in poor health are also most likely to pass on the same health condition to their children. Women's poor health also affects the economic well-being of the household, as they will be less productive in the labour force. Therefore, to look into the health problems

of women, it would be worth to look equally into the health needs of adolescent girls as adolescence is one of the crucial periods in a women's life.

The period of adolescence is regarded as a gateway to the promotion of health. To have a clear view of the health and developmental needs of adolescent girls, an attempt is made here, to examine the meaning, various definitions, different views and perceptions about adolescence in general. Attempts are also made to look into the many changes – the physiological, psychological and social changes that have taken place during adolescence. The health, nutrition and developmental needs of adolescent girls in relation to their socio-cultural environment is also be dealt with.

The word adolescence is Latin in origin, derived from the verb 'adolescere', which means 'to grow' or 'to grow to maturity'[17]. It is very difficult to define the period of adolescence. Adolescence is a modern cultural and social phenomenon and therefore the ages of adolescents vary by culture. There is still a debate going on the age of adolescence that is what age adolescence begins and when it emerges into adulthood as the time span is not the same for every person. Therefore, there are different assumptions and views on adolescent age.

The World Health Organisation (WHO) defines adolescence both in terms of age between 10 and 19 years and in terms of a phase of life marked by special developmental attributes such as rapid physical growth and development, physical, social and psychological maturity, but not all at same time, sexual maturity and the onset of sexual activity, experimentation, development of adult identity, transition from total socio-independence[18]. The United Nations Population Fund (UNFPA) has also given the age of adolescents as 10 to 19 years. In contrast, in the United States, adolescence is generally considered to begin between ages 12 and 14, and end at 19 or 20[19]. As distinct from adolescence, the word teenager is more easily defined as a person who is thirteen to nineteen years of age. In the Report of the Working Group, Government of India, Planning Commission, June 2001, the working group for the Tenth Five Year Plan has accepted age of adolescents from age 10 to 19 years[20].

The Government of India in its document on Youth Policy (2003) defines adolescence as 13 to 19 years age group[21].

The National Council for Educational Training and Research (NCERT) has divided the period of adolescence as[22].

I. Early adolescence (9-13 years)-characterised by a spurt of growth and the development of secondary sexual characteristics.

II. Mid adolescence (14-15 years) – this stage is distinguished by the development of a separate identity from parents, of new relationships with peer groups and the opposite sex, and of experimentation.

III. Late adolescence (16-19 years) - at this stage, adolescents has fully developed physical characteristics and has distinct identity and well-formed opinions and ideas.

In the light of the above mentioned meaning and definitions of adolescence, the only universal definition of adolescence is to mark it as a period in which a person is no longer a child and not yet an adult.

Adolescence is a period of rapid growth, development and change. Numerous changes take place, which are of vital importance in conditioning the behaviour and thinking of adolescents. This period of transition is characterised by a combination of physical, psychological and social changes. Generally, adolescence is a period of transition from puberty to adulthood. Puberty refers to the period of physical growth and the development of secondary sexual characteristics.

It is a known fact that girls began their pubertal development and attain full growth at an earlier age than boys attain. Girls grow faster in height and weight at approximately 12 years of ages, while it is approximately at 14 years for boys[23]. Young girls became aware of the physical changes taking place and this deeply

affected their thinking. Most of them develop some new feelings, which are very hard for them to understand. Menstruation may be very upsetting event for some girls who are not prepared for it. Young girls became self-conscious about their development if they believe their growth is not normal. This happens with those girls who mature late and when they are not growing as their friends. This is also true of those girls who mature early. They are taller and more developed sexually. This makes them feel awkward and self-conscious about her appearance because she is different from her pubertal friends[24].

Most researchers have pointed out that girls are more concerned than boys about their physical appearance. They are concerned about the size and shape of their breast, the dress they wear and other accessories. Tallness, pressure to remain thin, menstruation, underweight, defective teeth, defective speech and shortness are some of the major problems of concern for adolescent girls[25]. Because of this, early maturing girl are known to have more problems that are emotional, a lower self-image and higher rates of depression, anxiety and disordered eating[26]. This deeply affected their interests, their social behaviour and the quality of their affective life[27]. The evidence suggests that bodily changes play an important role in the overall development of adolescents.

This period of transition is also regarded as very crucial. Some young girls are unaware about the physical changes that have taken place. She is not informed about it, thus she lack knowledge on the biological processes of maturation and normal physiology. As discussion on sexuality is absent in Indian society, young girls are not prepared mentally for the physical changes. Thus, they began to have psychological problems, which may deteriorate their health condition. This is true more in case of young girls in a socially and economically backward family where discrimination is high. She is deprived of the attention and care; she needed most, so they are a burden on their families and has poor self-image as compared to their brothers.

Another important factor for psychological stress among adolescent girls is the onset of menstruation. Those young girls, who are not given information about menstruation prior to its onset, were frightened at the sight of blood for the first time. They are also vulnerable to infections if prior information about hygienic practices regarding menstruation is not given. In western societies, 'it is argued that menarche conveys conflicting societal messages, it represents the beginning of womanhood and sexuality, but girls of this age are seen as too young to be sexually active'[28]. In the Indian society, menstruation is considered a polluting factor among Hindus[29]. There are certain myths and taboos associated with menstruation. A menstruating girl/woman is restricted from cooking food, from touching anything in the kitchen or visit temple. While the girls/women are very knowledgeable about the myths and taboos, they have little knowledge about the biological processes of maturation and normal physiology.

Thus, young girls lack information on hygienic practice during menstruation, which consequently may increase susceptibility to various infections. A study showed that knowledge and awareness about puberty, menstruation, physical changes, reproduction, contraception, pregnancy, childbearing, reproductive tract infections (RTIs), sexually transmitted infections (STIs) and HIV was low among young adolescents in the age group 10-14 year[30]. Young girls in this age group are unaware and are not informed about menstruation prior to its onset. However, the study showed that among the older age group 15-19 year had better knowledge.

From a sociological point of view, the process of maturation during adolescence is the process of becoming socialised. Davis defines socialisation as the process by which individuals learn and adopt the ways, ideas, beliefs, values and norms of their culture and make them part of their personalities[31]. Each society defines the goals, values and behaviours it desires for its members. Socially acceptable behaviour is rewarded while unacceptable behaviour is

punished. Most of the factor that underlie the unhealthy development in adolescents results from the social environment in which they live as poverty and unemployment, gender and ethnic discrimination and the impact of social change on family and communities. Adolescents occupy an important position in the family as well as in the society.

The relationship of adolescents with their parents began to change at the early adolescent years as their life outside the family develops. Most parents are not as perfect as their adolescents would like them to be nor do most young people live up to all the expectations of parents. These results in some tension and conflict arise between an adolescent and his parents on matters that may seem unimportant to the parent although they are very important for the growing adolescent. The conflicts are on such matters concerning home chores, spending money, and apparent criticism of one child over another, dates, selection of friends, vocational choice and parental rejection or over protectiveness, and youthful impatience with parental opinion[32]. The changes in the relationship between adolescents and parents are found to become a factor of anxiety for parents and adversely affect the psychological development of adolescents. As children matured, parents in a good family have become friends with their children rather than the controllers of their children.

In a poor socially disadvantage family the period of adolescence for a young girl is for a limited period. This is because of the prevalence of gender discrimination and low socio-economic status where preference for son is high. Discrimination starts right from the birth of a female child. From lineage to religion and from appropriating a hefty dowry to earning for the family, everything points towards begetting a son, which leads to practice of female foeticide.

The health and well-being of adolescents - the future parents are very important. However, the importance of adolescents' health and of nutrition is

recognised recently. Adolescents make roughly 20 per cent of the total world population, of whom 85 per cent live in developing countries[33]. India has an estimated 200 million adolescents' population[34]. About one-fifth of India's population is in the adolescent age group 10-19 years[35]. Girls below 19 years of age comprised one quarter of the total rapid growing population of India[36]. Despite the huge growing adolescents' population, policies and programmes in India focused little on the health of adolescents as they are basically considered a healthy group having the lowest mortality and morbidity compared with other age groups.

In a family where discrimination is high, young girl receives inferior health care and nutritional needs. They are breastfed for shorter periods, have lower rates of immunisation and receive less nurturing than their brothers. During adolescence, the actual need for food is great. Nutritional health during adolescence is important for supporting the growing body and for preventing future health problems. Adolescent girls need additional calories, protein, calcium and iron. It is said that during adolescence, the attainment of maximum height, strength, other growth of the body and physical well-being depends upon good nutrition. Young girls need additional nutrients from age 13 to 15, need more calories than the average woman, 2,800 calories as compared with 2,500, but from age 16 to 18, the needs decrease and 2,400 calories are enough[37]. They also have a higher calcium requirement of 1500 mg daily[38]. They also need 10 per cent more iron as a result of menstrual blood loss, but their consumption is much less. Nutritional deficiency compounds the problem of malnutrition resulting in poor physical growth and may affect the whole life of the young girl. Poor nutrition is a major reason for the delayed onset of puberty in Indian adolescents[39]. It also reduces the reproductive, physical and mental capacities of girls in consequence resulting in low birth rates and high infant mortality.

Another visible health problem because of nutritional deficiency is the widely prevalent anaemia among adolescent girls of age group 15-19 years, compared with other age groups of women of reproductive age[40]. Both the 1992 ICMR study on iron and folic acid supplementation and UNICEF have also reported low mean hemoglobin levels and low nutritional intake of proteins, calories, and macro/micronutrients among adolescent girls and pregnant mothers[41]. Thus, we can see the importance of nutritional needs during adolescence period, which is necessary for healthy living.

The young girl is not only deprived of nutritional needs but also opportunities for education and employment. It is estimated that in developing countries, at any point in time, up to three-fourths of the children not attending school are girls[42]. Nearly twice the percentage of girls, 46.6 per cent are illiterate compared with males 25.5 per cent[43]. According to a report, 67 per cent adolescent girls in the age group 10-14 years attended school compared with 80.2 per cent of male adolescent[44]. Though there has been some improvement in the education of young girls, the probability that adolescent girls will drop out of school is still significantly high. Very few of adolescent girls attend and complete secondary school. Only 40.3 per cent of adolescent girls ages 15-17 attended school compared to 57.7 per cent of their male counterparts. On average, by the age of 18, girls have received 4.4 years less education than boys have[45]. Discrimination and increasing responsibilities of girls at home are the reason for girls dropping out of school.

A young girl always assists her mother in the household work and look after siblings. She is taught from the beginning to accommodate the male-dominated patriarchal society. She is married off early with no knowledge of reproductive health, increases the prevalence of early child bearing, and repeated pregnancy to beget a son. This makes the situation risky for both the child as well as the young mother. Premature marriages begin the vicious circle of malnutrition

where under-weight mothers have underweight babies who are at risk of suffering from nutrition and educational deprivation. This should be a cause for serious concern since many young girls are not physiologically mature for reproduction and they know little about the sexual and reproductive health. As a result, they are at a higher risk of unwanted pregnancies and various nutritional complicacies often leading to maternal death. Their offspring also suffer higher levels of morbidity and mortality. The Government of India 2000 Report says that 45 per cent of adolescent girls are under-nourished. It states that nutritional anaemia combined with early child bearing, puts adolescent girls at risk of maternal mortality and morbidity. It also reports that 40 per cent of young girls are married before the legal age of marriage i.e., 18 years. The Tenth Five-Year Plan also subsequently highlights that 47.8 per cent of adolescent married girls suffer from moderate to severe anaemia[46].

Therefore, with lack of nutrition, health care, and support from elders, the young girl suffers from various health problems. Moreover, inferior education lowers the young girl's self-esteem, her employment opportunities and her ability to take part in the world around her and later in life; she is likely to pass on her disadvantages to her children. Consequently, she is left with no future whereas an educated girl tends to delay marriage and childbirth and have fewer children. Thus, there is a close relation between educational attainment and age at marriage, fertility regulation and health seeking behaviour.

Even in a well-off family, because of influence of peers, media, widespread availability of information, and lack of parental care, young girls are no better than girls are in a poor family. As adolescence is a time of exploration and experimentation, their behaviour is guided by intense desire for independence and identity. They began to have serious interest in interacting with the opposite sex, in sexual relationships and may indulge in more readily available harmful substances such as tobacco, alcohol and other drug use which without timely

intervention may lead to risky behavioural pattern and other health risk that last a lifetime. Another serious problem is that adolescents lack information on sexual and reproductive health and use of contraception.

Thus, there is the threat of spreading of STDs, RTIs and HIV/AIDS. In India, one-half of all young women are thought to be sexually active by the time they are 18, and almost one in five are sexually active by the time they are 15 year old. There are also reports of approximately 10 million pregnant adolescents and adolescent mothers throughout India at any given time. In a study, it was revealed that a large percentage of adolescent boys and girls engaged themselves in non-penetrative sexual experiences such as kissing, hugging, touching sexual organs, etc. but only 26 per cent of boys and 3 per cent of girls reported that they had experience sexual intercourse. It was also revealed that 50 per cent of the boys have knowledge about contraception[47].

Thus, Reproductive health, Sexually Transmitted Diseases (STDs), Reproductive Tract Infections (RTIs), Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and early pregnancy is understandably a major concern, which required special needs and concerns of adolescents. Increasing the age at marriage and providing adolescents their health and developmental needs will help in determining the future size and growth pattern of India's population.

As mentioned before, in the past decade, the United Nations major global conferences and conventions such as the World Conference on Population and Development (ICPD), Convention on Rights of the Child (CRC) and Fourth World conference on Women (FWCW) have given higher emphasis on health issues particularly the reproductive health and have initiated and supported a number of programmes of the needs and rights of adolescent girls and women. Since then, India has signed and ratified all major conferences and conventions, which helps in increasing policy attention towards adolescent girls and women for improving their

health status, which will in future enable them to make good choices for themselves and their communities. For this to happen adolescent girls and women must be provided free legal access to information and their rights must be guaranteed and protected by law.

Women in Manipur: An overview

In the early period of history, women in Manipur held a very high social position and status. This can be traced back to the mythological figures like Imoinu, Panthoibi, Phouoibi, Ima Leimaren etc and legendary figures like Thoibi, Tonu Laijinglembi, Pidoinu etc. Imoinu is still worshipped as the Goddess of wealth in every house of the *meitei* (the dominant community inhabiting in the valley). Once she falls in love with a man to whom she finds out to be a married man. After knowing this, she is determined not to see that man again and spent all her life by rendering help to the people of *meitei* society. She prescribes certain norms and behaviours, which are followed by the housewife; the family would be happy and prosperous. Panthoibi is worshipped as the Goddess of war. She was found to be assertive and independent. She falls in love with a man but her parents gave her in marriage to another man against her wishes. Later on, she succeeds in running away with the man she loves.

This shows that women during those days exercised her right of choosing her life partner. Another legendary figure Thoibi also makes her own decision in choosing her life partner. Overall, women in the mythology of Manipur were bold, courageous, and independent, enjoyed their due rights and had a hounourable place in society. There are also eminent women figures in the history of Manipur like Lingthoinganbi, Kuranga Nayani, Kumudini etc who contributed a lot in protecting the territorial integrity as well as the throne of Manipur by fighting against enemies. During the Pre-British period, women had to bear the burden of household responsibilities along with earning for the family. This is because all

adult male members of a family were engaged in warfare activities along with the king, against the neighbouring enemies. In normal days also, the male members had to attend the *"Lallup"* or military training in the palace[48]. Many men were killed and many were taken away as war prisoners. As a result, many women became widows and thus had to shoulder social responsibilities in the absence of their husbands. They started selling and buying of essential commodities, which in course of time developed into a market, where women in large numbers congregate and share their views relating to the socio-economic as well as political matter.

E.W Dun made a comparative study on the characteristics of both men and women of Manipur and he stated that Manipuri women are very industrious while men are described as lazy and indolent[49]. During the British rule, two women's movements emerged in 1904 and 1939, due to women's presence as collective force in the market place. The first, 1904 movement known as "Nupilan Ahanba" (first women's war) was against the British authority to review the Lallup system in Manipur. This movement forced the British to review its policies. The 1939 women's movement also known as "Anisuba Nupilan" (second women's war) was also against the British authority to stop the export of rice from the Manipur. This was due to the scarcity of rice in Manipur. Because of the movement, the British discontinued the export of rice. Some of the prominent leaders who played vital role in the women's movement were A. Rajani, R.K. Sanatombi, T. Shabi, M. Indumukhi and L. Ibemhal etc.

After Independence in 1975, another women's movement known as *Nisha Bandh* (Anti liquour movement) was engineered. This women's movement fought against the selling, buying and drinking of liquour and anti-social activities that disturbed the peace and social order in Manipur. In the late 70s due to the political instability in the state, a series of political problems emerged such as the emergence of insurgency. A clash between the insurgency groups and the security

forces resulted into the death of innocent people, physical injury and mental torture. Women became the worst sufferers. Thus to protect the innocent persons, women's movement called Meira Paibis (torchbearers) was formed in the 80s. They also resolved family conflict, checked immoral trafficking, drug trafficking etc. The Meira Paibis from time to time organised rallies; sit in protest, etc. to highlight their feelings.

Politically, women of Manipur lagged behind in comparison to other states of India. Although women voters outnumbered male voters, very few women are elected since the assembly election, 1972. The selected women candidates belong to political families who are supported by their husbands. This shows that the decision-making is still in the hands of men where common women will take time to come to the forefront in political sphere of the state.

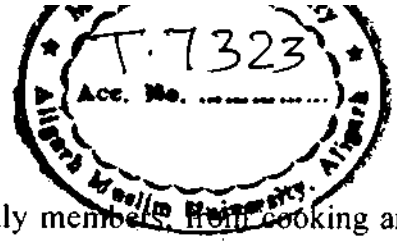
Quite interestingly, the NFHS-3 reveals that Manipuri women account for 85 per cent in the family decision-making[50]. There is a consensus among men that women who participate fully in the decision-making would not face any problem of domestic violence against themselves. Contrary to the above NFHS-3(2005-2006) further reveals that 42 per cent of women of Manipur faced spousal violence and Manipur stand 4th rank in India. There are various causes of violence viz.; poverty, divorce, judicial separation, conflict, status quo, alcoholism, drug abuse, economic disparity, unequal power equations HIV/AIDS etc. All these problems would have an adverse impact on the health of women, as women's health is intimately tied with the health of the children and that of the family as a whole.

Health needs adolescent girls and women in Manipur

In the Meitei society since the time immemorial, there has been a trend of preference for a male child at first birth. This preference for a son is in tune with the patrilineal principal of their social organisation. Therefore, a male child is always welcomed, as he is the protector of the lineage line and also gives in old

age. More over the mother who has given birth to an eldest son has a highest ritual status than the mother who has given birth to an eldest daughter. Generally, a mother with an eldest son is regarded as a symbol of goodness and welfare. A girl child faces less discrimination in the *meitei* society and she is never considered a burden to the parents. She also faces less pressure to marry early. However, a daughter is always expected to assist her mother in household activities, to take care of her younger siblings and to attend on the elderly members of the family, while it is not a compulsion on boys. This unequal treatment of parents will certainly lead to the girl child receiving less care, food and education from their parents, which will in turn bring health problems in their later life. Again, in *meitei* society, talking about sex is taboo, so young girls are not given the required physical, sexual and reproductive health information. As a result, they are at a higher risk to suffer from depression and various other health problems associated with it. As young girls attain puberty, they go through a stage where their bodies grow much more rapidly to prepare them for childbearing. Nevertheless, due to the poor economic situation of the state and their urge to remain slim, to rate better in marriage market, they consumed less food.

Thus, they are deprived of various nutritional needs that increased her vulnerability to the risks of growth retardation and particularly risk in childrearing as well as for the child to be born. Their nutritional needs are further deprived by the culturally prescribed dos and don'ts for a menstruating girl. She is refrain from eating all types of fruits and vegetables peruk (*Centella asiatica*), nongmangkha (*Adhatoda visica*), Yongchak (*Parkia roxburgii*), Banana flower (*Musa paradisiaca*), brinjal (*Solanum melongena*) and particular curry known as Utti [a curry prepared by mixing pulse, vegetables and soda (sodium carbonate)] for six days. It is believed in the *meitei* society that if one consumed all those said food; she would become unhealthy and blackish in complexion. Young girls also suffered from mental tensions when they are treated like untouchable during those



six days. She is restricted from touching any family members, from cooking and serving food, and is not allowed to dine with others. She is prohibited from performing any ritual and from entering sacred places like temples.

The same rule is for married women also. In addition to the above mention restrictions, a married woman is not allowed to perform any ritual and religious ceremonies as they are regarded as polluted for a whole three months after delivery of child. The ritualistic belief is so strong in *meitei* society that women in Manipur continue to observe this food taboos and rituals even at the expense of their health[51].

Many young adolescent girls enter into sexual life and childbearing with no knowledge about sex and the reproduction processes. Thus, gave birth to low weight babies and run a high risk of life. They often do not have the power to insist on safe and responsible sex practices and have little access to information and services for prevention and treatment. Therefore, they are also very vulnerable to STDs, RTIs and HIV/AIDS etc. Manipur being a border area drugs like Heroin is easily brought from Myanmar. The numbers of injecting drug users are therefore increasing in Manipur that is why there is high prevalence of HIV/AIDS in the state. Because of it, the number of widows is increasing in Manipur, which affects the health of not only themselves but also of their children and the family as a whole. The consequences of HIV/AIDS reach beyond women's health to their role as mother and caregivers and their contribution to the economic support of their families. Some of the greatest or main challenges that the Manipuri women faced at present which adversely affect their health are the increasing socio-economic problem; drugs; HIV/AIDS; ethnic crisis; armed conflict where women faces many serious problems such as sexual abuse, rape, killing etc.; low political participation of women in the state etc. Thus, women of Manipur are the one to be worst affected from these above-mentioned problems in the present days Manipur.

It will be appropriate to elucidate here the demographic and health profile of Manipur. According to the 2001 census, the total population of the state is 23, 886, 34. The decadal growth rate of the state is 30.02 per cent as against the all India level of 21.34 per cent. The density of population is 107 persons per square kilometers, much lower than that of all India 324. The process of urbanisation in the state is found to be very slow but Manipur ranks second among the northeastern state of India in respect to urbanisation. The urban population has increased from 5.06 lakhs in 1991 to 5.76 lakhs in 2001[52]. The literacy rate is 68.87 per cent and male percentage is 77.87 percent whereas female is 59.70 per cent[53].

Historically, Manipur has had a higher sex ratio at birth than the all India figure. The sex ratio which represents the survival scene of women, registered an improvement from 958 (females per 1000 males) in 1991 to 978 (females per 1000 males in 2001) much higher than the all India level of 933. but we can still see the imbalance in the sex ratio. Life expectancy is another indicator of how healthy one can expect to be. Inequalities in this area have the most fundamental bearing on well-being and opportunities[54]. Life expectancy rates of Manipur and India have increased over the years, however most recent data available for life expectancy for Manipur are for 1991. Therefore, comparisons with the all India figures are not possible. In 1991, the life expectancy of females in Manipur was greater than that of males. It was 58 for males and 61.50 for females while it was 58.1 and 58.6 (for India)[55]. According to Sample Registration System Bulletin, the birth rates in Manipur declined from 20.1in 1991 to 18.3 in 2001 and death rate from 5.4 in 1991 to 5.2 in 2001[56]all India birth rate is 20.20 and death rate is 8.40[57].

According to the NFHS (National Family Health Survey) –3, the IMR per 1000 live births in Manipur has a steady decline from 42 (NFHS-1) to 37 (NFHS-2) and at present comes down to 30[58]. However, the IMR of Goa and Kerala is at 15 each. This shows that the health status of Manipuri women is lower than Goans

and Keralites women. The NFHS-3 (2005-06) also reveals that 42 per cent women of Manipur faced spousal violence and is in the fourth rank in India. This shows that domestic violence is highly rampant in Manipur, which may have a significant public health consequence including effects on unwanted fertility and contraceptive use, rates of HIV and other health care. All these may adversely affect the mental and physical well being of women and consequently their children.

Government policies and programmes for adolescent girls and women

The Government of India had ushered in the new millennium by declaring the year 2001 as 'Women's Empowerment Year' to focus on a vision 'where women are equal partners like men'. The most common explanation of 'women's empowerment' is the ability to exercise full control over one's actions. The last decades have witnessed some basic changes in the status and role of women in our society. There has been shift in policy approaches from the concept of 'welfare' in the seventies to 'development' in the eighties and now to 'empowerment' in the nineties.

Several legislative provisions have been introduced that directly or indirectly protect the rights of adolescents. Some Constitutional Provisions affecting adolescents are such as Article 15, Article 16, Article 21, Article 23, Article 24, Article 39 (c), Article 39 (d), Article 39 (e), Article 39 (f), Article 40, Article 42, Article 45, Article 46 and Article 47. Besides, the constitutional provisions, legislative Acts have also been promulgated to safeguard the health and social protection of children (including adolescents) such as the Immoral Traffic Prevention Act, 1956; the Child Marriage Restraint Act, 1976; Child Labour Prevention and Regulation Act, 1986; the juvenile Justice Act, 1986; Pre-natal Diagnostic Technique (Regulation and Misuse) Act, 1994; Persons with Disability/Equal opportunities, Protection of Rights and Full Participation Act, 1996.

All round development of women has been one of the focal points of planning process in the various Five Year Plans of the Government of India. Within the development plans, improving the health of women and children has been given special attention. After independence, we have had ten Five Year Plans, which are as described below.

The Government of India (GOI) has framed and announced its development strategies through Five-Year Plans. The Government of India right from the very first plan (1951-56) had recognised the importance of the role of women in development. The First Five Year Plan (1951-56) was mainly welfare oriented. This Plan envisaged a number of welfare measures for women such as the establishment of the Central Social Welfare Board (CSWB) in 1953 that served as an apex body at the national level to promote voluntary action at various levels, especially at the grassroots, to take up the welfare-related activities for women and children. The Plan further recognised women in the reproductive age groups and children as especially vulnerable groups. Under the section on health, maternity and child health service is kept at the forefront in the planning of health programmes. The First Plan also stated that protecting the health of the expectant mother and her child is the most important way for building a sound and healthy nation. The Plan aimed at developing maternity and child health centres, which are properly equipped with adequate number of staff to provide them the health services.

There were no philosophical or conceptual changes in the Second to Fifth Plans (1956-79), as the same welfare approach is continued besides giving priority to women's education , and various measures were taken up to improve maternal and child health services, supplementary feeding for children and expectant and nursing mothers. Women's Welfare and Development Bureau was set up under the Ministry of Social Welfare. The Fifth Five Year Plan (1974-78) is considered very crucial from the point of view of women development with 1975 being declared as 'International Year of Women'. The plan identified areas of health, family planning, nutrition,

education, employment, legislation, and social welfare for formulating and implementing action programmes for women and called for planned intervention to improve the condition of women in India.

The Sixth Five Year Plan (1980-85) saw a definite shift from welfare approach to development approach. The Plan recognised women's lack of access to resources as one of the important factor impending their growth. The strategies for women's employment and economic independence, education, health care and family planning and the creation of a supportive legal and institutional environment were conceived. It was in the Sixth Plan document that women were recognised as a separate group by including a separate chapter on 'Women and Development'. Accordingly, the Sixth Plan adopted a multi-disciplinary approach with a special thrust on the three core sectors of health, education and employment. Since then all efforts of the Government of India have been directed towards bringing women into the mainstream of the national development process by raising their overall status- social, economic, political and legal.

Development approach is continued in the Seventh Five Year Plan (1985-90) which aimed at raising the economic and social status of women and bringing them into the mainstream of development of the country. A significant step in this direction was the identification and promotion of the 'Beneficiary-Oriented schemes' (BOS) in various developmental sectors, which extended direct benefits to women. The Seventh Plan emphasised the need for gender equality and empowerment. The Plan also recognised that the health and nutrition status of women are important factors, which affect child survival and development. Thus, for improving the health and nutrition status of women, maternal and child services were strengthened in the Seventh Five Year Plan. The Universal Immunisation Programme, which aims at universal coverage of pregnant women and infants, was extended to all districts in the country. Increasing the age of marriage, adoption of two-child norm and spacing of births was

vigorously promoted, to project family planning as a programme for the well-being of the mother and her child.

In the year 1985, the Department of Women and Child Development was set up as part of the Ministry of Human Resource Development. For the advancement of women and children, the Department formulates plans, policies and programmes; enacts/amends legislation, guides and coordinates the efforts of both Government and Non-Governmental Organisations (NGOs) working for women and child development. The Department has also been implementing the Integrated Child Development Scheme (ICDS), providing a package of services comprising supplementary nutrition, immunisation, health check-up and referral services, pre-school non-formal education. The major policy initiatives undertaken by the Department includes the establishment of the National Commission for Women (NCW), Rashtriya Mahila Kosh (RMK), adoption of National Nutrition Policy (NNP), universalising and strengthening of ICDS, setting up of National Crèche Fund (NCF), launching of Indira Mahila Yojana (IMY), Balika Samridhi Yojana (BSY) and Rural Women's Development and Empowerment Project (RWDEP).

The Eight Five Year Plan (1992-97) focused on human development. The Plan marked a shift from development to empowerment. It focused on empowering women, especially at the grassroots level, through Panchayati Raj Institutions. Efforts would be made to facilitate women's access to, and control over and use of locally available foods to ensure adequate nutrition, particularly iron and iodine intake. Nutrition Programmes will lay emphasis on nutrition education, particularly increasing the awareness about the nutritional needs of women especially during infancy, adolescence, pregnancy and breastfeeding of the newborn. The Eight Plan contemplated universalisation of Integrated Child Development Services Scheme.

In the Ninth Five Year Plan (1997-2002), empowerment of women became one of the nine primary objectives. The Plan also attempted convergence of existing services in both women-specific and women related sectors. To this effect, the Plan

adopted a Women's Component Plan (WCP), under which not less than 30 per cent of funds/benefits are earmarked for women-specific programmes. The Ninth Five Year Plan recognises the special health needs of women, the girl child, and the importance of enhancing easy access to primary health care. There is specific mention of adolescents in the Ninth Plan, which emphasises its commitments towards the child, to universalise supplementary feeding with a special emphasis on adolescent girls, to expand the adolescent girls' scheme and to assess the health needs of adolescents in the RCH programme. Nevertheless, adolescents continue to be a sub-group of women, children or youth. The year 2001 is declared as 'women's Empowerment Year' which saw various activities and programmes specially aimed at women including the much talked about women's self-help groups (SHGs).

The neglect in the health needs of women viz., the pregnant women, adolescent girls and girl-babies, is responsible for the present high rates of Infant Mortality Rate/Child Mortality Rate/Maternal Mortality Rate. Therefore, a holistic approach with RCH measures is to be adopted in improving health status of women by focusing on their age specific needs. ICDS continues to be the major intervention for the overall development of children. It caters to the pre-school children below six years and expectant mothers with a package services viz., immunisation, health check-ups, referral services, supplementary nutrition, pre-school education, and health and nutrition education. During the Ninth Plan period, several new initiatives are taken as part of the Reproductive Child Health Programme (1997), in order to make it broad-based and client-friendly.

The Tenth Five Year Plan (2002-2007), is different from the earlier plans as it borrows from the Platform for Action with definite goals, targets and a time-frame and expects to continue the process of empowering women initiated during the Ninth Plan[59]. The plan aims at the operational strategy in terms of a time-bound action plan; responsibilities of the executing agencies, both government and non-government; built-in mechanism for coordination, monitoring, and evaluation of impact through

measurable indices, etc. The plan also promotes SHG mode to act as agents of social change, development and empowerment of women.

Thus, the Tenth Plan (2002-2007), aims at empowering women through the National Policy for Empowerment of Women (2001) and ensuring Survival, Protection and Development of Women and Children through Rights Based Approach. The focus shifted from the individualised vertical interventions to a more holistic integrated life-cycle approach to women's health with more attention to reproductive health care.

However, in the Tenth Five Year Plan (2002-2007)[60], there is still no more to consider adolescents as a separate group/category but they continue to be a sub-group of women, children or youth. The 10th Five-Year Plan states that adolescent girls (15-19 years) are very sensitive from the point of view of planning because of the preparatory stage for their future production and reproductive roles in the society as well as the family. The 10th Five Year Plan is committed to improve the accessibility and utilisation of services of primary health care and family welfare particularly, the undeserved and underprivileged sections through universalising reproductive and child health services and reiterates to achieve the goals set by the National Health and Population Policies to reduce Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR). The commitment to adolescent girls also include universalisation of Integrated Child Development Services (ICDS) Scheme and nutrition supplementary feeding programmes for tackling nutritional deficiencies, to increase enrolment/retention rate and reducing drop-outs, to strengthen and expand the schemes for adolescent girls and encouraging media to project positive images of women and girl child.

The Plan stated that women in the reproductive age group 15-44 years need special care and attention because of their reproductive needs. The commitment of Tenth Five Year Plan includes universalisation of Reproductive and Child Health services to achieve the goals set by the National Health and Population Policies,

especially with regard to women and child. Other effective measures includes obstetric care through early registration of pregnancy and screening of all pregnant women at least thrice during this period to detect risk factors; identification and management of anaemia and hypertension disorders; providing referral care to 'at-risk' mothers and to ensure safe delivery. Services for the prevention and management of RTIs, and STIs are also continued as part of RCH care.

The Government in different Five Year Plans has enunciated the policies advocating women's issues including women's health. The Government has also consciously fostered on enabling environment in which women's issues can be properly reflected, articulated and seriously addressed. It was in the year 1951, where India's Family Planning Programme was initiated for the first time, in an effort to stabilise the huge growing population of the country. Since then, the policy, approach, and implementation of the Family Welfare Programme has undergone a number of changes and has embraced six major approaches viz., the clinical approach (1951-61), extension and education approach-low intensity HITTS (Health department operated, Incentive based, Target-oriented, Time-bound, and sterilisation-focused Programme) approach (1962-69), high intensity HITTS approach (1969-75), coercive approach (1976-77).

Under the clinical approach (1951-61), the family planning coverage was negligible, with the couple protection rate (CPR) remaining at about 0.2 per cent. The CPR rose to 15 per cent in 1975 with the introduction of the extension and education approach (1962-69). The programme suffered a setback during the coercive approach (1976-77). During the recovery phase, the family planning programme was integrated with maternal and child services. Since then, variety of services has been provided to mothers and children, including antenatal, delivery, and postnatal care, immunisation of children against various vaccine-preventable diseases, and counseling on maternal and child health problems and nutrition. The CPR increased from 24 per cent in 1977 to 45 per cent in 1992-93. The Government of India as part of the family planning

programme launched the Child Survival and Safe Motherhood (CSSM) Programme. The component of this programme includes an integrated package of interventions for improving the health status of mothers and children. The programme also includes treatment of diarrhoea and acute respiratory infections, essential newborn care, and strengthening of emergency obstetric care services.

In response to the International Conference on Population and Development (ICPD), the Government of India launched the Reproductive and Child Health (RCH) Programme in 1997 incorporating new approach to population and development issues, as exposed in the ICPD. The Programme integrated and strengthened Child Survival and Safe Motherhood Programme and Family Planning Services and the treatment of Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs) was added to the existing services.

In the last couple of years, the Government of India has not yet formulated specific policies for adolescents; however, several plans and policies have components that address adolescent health and needs. Some of the policies and programmes for adolescent girls and women are listed as follows: The National Nutrition Policy 1993, the National Plan of Action on Children, 1992 and 2005, the National Education Policy, 1986 (modified in 1992), the National Policy for the Empowerment of Women, 2001, the National Population Policy, 2000, the National AIDS Policy, 2000, the National Youth Policy, 2003, The National Rural Health Mission, 2005-2012, etc.

Some other government interventions towards economic and social empowerment of women are listed as follows: National Perspective Plan for Women (1988), Shramshakti – the Report of the National Commission for Self – Employed Women and Women in the Informal Sector (1988), Support to Training and Employment Programme for Women (STEP), Employment - Cum – Income Generation – Cum Production Units, Condensed Courses of Education and Vocational Training for Adult women (CCE & VT), Socio – Economic Programme (SEP),

Rashtriya Mahila Kosh (RMK), Mahila Samriddhi Yojana (MSY), Indira Mahila Yojana (IMY), National Commission for Women (NCW), National Resource Centre for Women, Gender Sensitisation and Awareness Generation, The National Plan of action for Children (1992), National Plan of Action for Girl Child (1991-2000 AD), Legal Literacy Manuals, Reservation for Women in Grass-root Level Democratic Institutions (1993), Support Services, Monitoring of Beneficiary Oriented Schemes (BOS) for Women.

In summary, there is no doubt about the fact that development of women has always been the central focus of planning since Independence. However, gender issues continued to be framed by dominant patriarchal ideologies and discourses even as institutionalised attempts were being brought in place for expanding spaces for women in a greater equity paradigm. Empowerment is a major step in this direction but it has to be seen in a relational context. A clear vision is needed to remove the obstacles to the path of women's emancipation both from the government and women themselves. Efforts should be directed towards all round development of each and every section of Indian women by giving them their due share.

References:

[1] Murdock, G.P, (1949), Social Structure, Macmillan, New York.

[2] Parsons, T, (1959), The Social Structure of the Family In the Family: Its Functions and Destiny, R. N. Anshen (ed.), Harper &Row, New York.

[3] Bowlby, J, (1953), Child Care and the Growth of Love, Penguin Books, Harmondsworth.

[4] Oakly, A, (1974), Housewife, Allen Lane, London.

[5] Friedl, E, (1975), Women and Men: An Anthropological View, Holt, Rinehart & Winston, New York.

[6] Malladi Subbamma, (1985), Women, Tradition and Culture, Sterling Publishers Private Ltd. New Delhi, P-15.

[7] Bakshi S.R, Kiran Bala, (2000), Social Status and Role of Women, Deep and Deep Publications Pvt. Ltd. New Delhi, P-185.

[8] Seth, Mira (2000), Women and Development: The Indian Experience, Sage Publications, New Delhi. Thousand Oaks, London, P-17.

[9] Ibid, P-18.

[10] Bakshi. S.R. Kiran Bala. (2000). . op. cit.

[11] Seth. Mira (2000). Op. cit.

[12] Malladi Subbamma. (1985). . op. cit.

[13] Sangh Mittra and Bachchan Kumar, (2004), Encyclopaedia of Women in S. Asia (In 8 Volumes) Vol-1 India, Kalpaz Pulblications Delhi, P-3.

[14] Ibid.

[15] Seth, Mira, (2000). op.cit.

[16] Planning Commission, (2004), Tenth Five Year Plan, (2002-2007), Chapter 2.11, Women and Children, Yojana Bhavan, Government of India, New Delhi. http://planningcommission.nic.in/plans/planrel/fiveyr/10th/volume2/v2_ch2_11.pdf

[17] Golinko, B.E, (1984), Adolescence: Common Pathways through life, Adolescence, 19, 749-751.

[18] WHO, (2005), Nutrition in Adolescence: Issues and Challenges for the health sector; issues in adolescent health and development (WHO discussion papers on adolescence), WHO, www.who.int/child-adolescent-health/new-publications/ADH/ISBN_92_4_159366_0.pdf (08.02.07).

[19] Goodburn, Elizabeth. A and Ross, David. A, (1995), A Picture of Health: A Review and Annotated Bibliography of the Health of Young People in Developing Countries, Published by the World Health Organisation and UNICEF.

[20] Planning Commission, (2001), Report on the Working Group on Adolescents for the Tenth Five Year Plan, (2002-2007), Government of India, New Delhi. http://planningcommission.nic.in/aboutus/committee/wrkgrp/wg_adolcnts.pdf.

[21] Ministry of Human Resource Development (MHRD), (2003), National Youth Policy, 2003, Department of Youth Affairs and Sports, Government of India, New Delhi, MHRD. http://yas.nic.in/yasroot/policies/youth_policy_03.htm#NATIONAL (19.02.07).

[22] Pandey, J. Yadav, et. al., (1999), Adolescence Education in Schools: Package of Basis Materials, National Population Education Project, National Council of Educational Research and Training, New Delhi.

[23]Tanner, J. M, (1972), Sequence, Tempo and Individual Variation in Growth and Development of Boys and Girls Aged Twelve to Sixteen: Early Adolescence, (eds) J. Kegan and Robert Coles, New York, W.W. Norton and Co.

[24] Rice, F. Philip, (1990), The Adolescent Development, Relationships and Culture, (sixth edition), Allyn and Bacon, Boston, London, Sydney, Toronto, 162.

[25] Cole, Leulla, (1962), Psychology of Adolescence, Holt, Rinehart and Winston, New York (fifth edition), 89.

[26] Ge X, et. al., (1996), Coming of Age Too Early: Pubertal influences on Girls' Vulnerability to Psychological Distress, Child Development, 7, 3386-3400.

[27] Blos, Peter, (1962), On Adolescence, A psychoanalytical Interpretation, Glencoe, Inc. U.S.A.,

[28] Wichstrom, L, (1999), The Emergence of Gender Difference in Depressed Mood during Adolescence: the Role of Intensified Gender Socialisation, Development Psychology, 35, pp.232-45.

[29] Shukla. S. (2005), Working on Menstruation with Girls in Mumbai. India: Vacha Women's Resource Centre: EQUALS, (15) pp. 5.

[30] Indian Council of Medical Research, ICMR, (1992), Task Force study on Field Supplementation, Trial in pregnant women with 60 MG, 120 MG and 180 MG of Iron with 500 G of Folic Acid, New Delhi, Indian Council of Medical Research.

[31] Davis, Allison, (1944), Socialisation and adolescent personality, In Adolescence, Yearbook of the National Society for the Study of Education, Vol. 43, Part. 1.

[32] Crow, Lester. D and Crow Alice, (1956), Adolescent Development and adjustment, McGraw, Hill book Company, Inc. New York, Toronto, London, 387.

[33] WHO, UNFPA, UNICEF, (1995), Action for Adolescent Health, Towards a Common Agenda, Recommendations from a Joint Study Group

http://www.who.int/child-adolescent-health/New_publications/ADH/WHO_FRH_ADH_97.9_en.pdf (8.02.07).

[34] Centre for Development and Population Activities, CEDPA, (2001), Adolescent Girls in India Choose a Better Future: An impact Assessment. www.cedpa.org/content/publications/detail/634.

[35] Census of India, (1991), Registrar General and Census Commissioner 1991, Government of India.

[36] Bezbaruah, Supriti and Janeja, Mandeep. K, (2000), Adolescents in India: A Profile, UNFPA for UN system in India, www.un.org.in/adolescentsfinalbook-800kb.pdf (11.02.07).

[37] Cole, Leulla, (1962), Psychology of Adolescence, Holt, Rinehart and Winston, New York (fifth edition), 89.

[38] WHO, (2005), Nutrition in Adolescence, WHO. , op. cit.

[39] Ibid.

[40] Shesadri, Subadra, (1997), Epidemiology of Nutritional Anemia among Pregnant and Lactating Women, Adolescent Girls and Pre-School Children: Baroda: Maharaja Sayaji Rao University of Baroda.

[41] Shesadri, Subadra, (1997), Epidemiology of Nutritional Anemia among Pregnant and Lactating Women, Adolescent Girls and Pre-School Children: Baroda: Maharaja Sayaji Rao University of Baroda.

[42] Centre for Development and Population Activities, CEDPA, (2001), Adolescent Girls in India Choose a Better Future: An impact Assessment. www.cedpa.org/content/publications/detail/634

[43] International Institute of Population Sciences, IIPS (2000), National Family Health Survey (NFHS-2)1998-99, Mumbai: International Institute of Population Sciences.

[44] Ibid.

[45] Black, Maggie, (1994), Girls and Women: A UNICEF Development Priority, New York, 1994, pp. 23.

[46] Planning Commission, (2004), Tenth Five Year Plan, (2002-2007). , op. cit.

[47] Abraham, Leena, (2001), Understanding Youth sexuality: A Study of College Students in Mumbai City, The Indian Journal of Social Work, 62(2).

[48] Dun, E. W (1975), Gazetteer of Manipur (fourth edition), Vivek publishing Company, New Delhi.

[49] Ibid.

[50] International Institute of Population Sciences, IIPS, (2007), National Family Health Survey-3 (2005-06), Government of India, New Delhi, IIPS. http://mohfw.nic.in/nfhs3/installreader.htm

[51] Ghosh, G. K, et. al., (1997), Women of Manipur, A.P.H. Publishing Corporation, New Delhi.

[52] Economic Survey Manipur, (2005-06), Directorate of Economics and Statistics, Government of Manipur.

[53] Census of India, (2001), Directorate of Census Operations, Manipur.

[54] Human Development Report, (2005), Oxford University Press, New Delhi, Published for the United Nations Development Programme (UNDP).

[55] Census of India, (1991), Registrar General and Census Commissioner 1991, Government of India.

[56] Economic Survey Manipur, (2005-06). , op. cit.

[57] Census of India, (2001), Directorate of Census Operations, Manipur.

[58] International Institute of Population Sciences, IIPS, (2007), National Family Health Survey-3 (2005-06), Government of India, New Delhi, IIPS, http://mohfw.nic.in/nfhs3/installreader.htm .

[59] Planning Commission, (2004), 10th Five Year Plan (2002-2007), Chapter 2.11, http://www.planningcommission.nic.in/, 1 October.

[60] Ibid.

CHAPTER III

EMPOWERING ADOLESCENT GIRLS IN RESPECT TO HEALTH

CHAPTER III

EMPOWERING ADOLESCENT GIRLS IN RESPECT TO HEALTH

In this chapter an attempt is made to have a clear view of the health and developmental needs of the adolescent girls particularly of Manipur state. The chapter examines how far adolescent girls are benefited from the various Governmental Policies and Programmes mentioned earlier. This is seen through adolescent girl's level of awareness, the problems and reactions regarding the physiological, psychological and social changes that have taken place due to the onset of puberty. The nutritional needs of adolescent girls in relation to their socio-cultural environment and also their knowledge on contraception, pregnancy, and childbirth, RTIs, STIs, and HIV/AIDS etc is look into. The present chapter is based on both primary and secondary sources.

The health needs of women is said to differ in different stages of her life. Adolescence is an important period in a women's life-cycle. Sohoni, N.K[1] states that the girl in every woman precedes and shapes the woman in her and to the extent to which girlhood is denied, liberated, and fostered, womanhood perishes or prospers. As mentioned earlier, adolescence is usually a time of good health for girls but also a time of risk particularly regarding their lack of awareness on their health care, reproductive health, sexual activity and substance use. Preventing and dealing with such risks is necessary for their health and also their future health when they mature into adults, as adolescents account the initial period of the reproductive age group. Thus, the health of adolescents sets the stage for their future health and well-being, as well as for the health of their children and the development of the society as well.

Keeping this background in mind, the researcher carried out a survey of selected areas of Manipur in order to explore the empowerment of women more

particularly, the adolescent girls in regard to their health. The data thus collected and its interpretations are being given as under:

Results and discussion

Profile of Adolescent Girls

Age:

Age of a person is an important factor more so in the case of adolescent girls who are of different age groups. The age at which adolescent girls become matured physically, emotionally and socially varies from one girl to another. With the physical changes that have taken place, it is possible to recognise the changes in adolescent girl's attitudes, performance and behaviour patterns. Many of the rights for instance the right to vote, right to marriage, right to inherit property etc. is controlled by age. At reaching a particular age, she may be given the right to vote even though she may be emotionally and socially immature. They are married off young when they are not physically mature. Different strategies need to be adopted for providing different types of services for empowering the adolescent girls.

Information relevant to the age of the respondents has been collected and tabulated in table 3.1.

TABLE NO. 3.1

AGE STRUCTURE OF RESPONDENTS

Age group	No. of respondents	Percentage
11-13	20	20
14-16	46	46
17-19	32	32
Total	**100**	**100**

Source: Field Survey

FIGURE 3.1: SOCIAL BACKGROUND OF THE RESPONDENTS

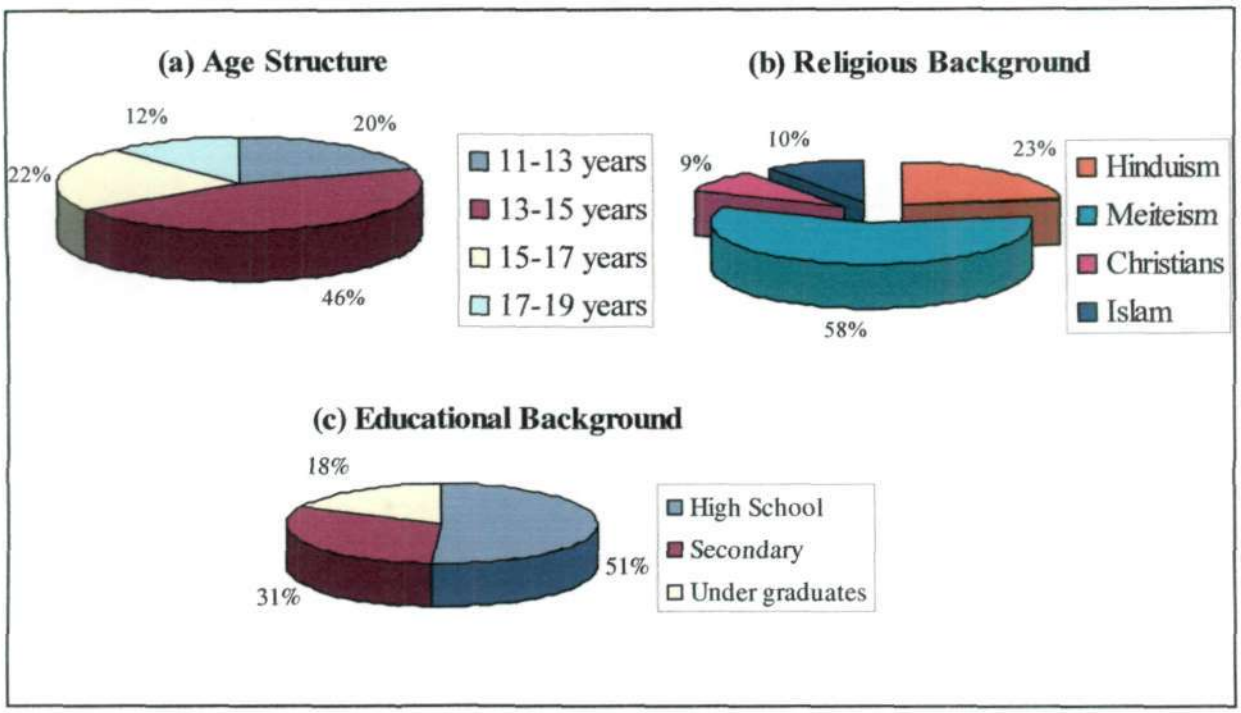
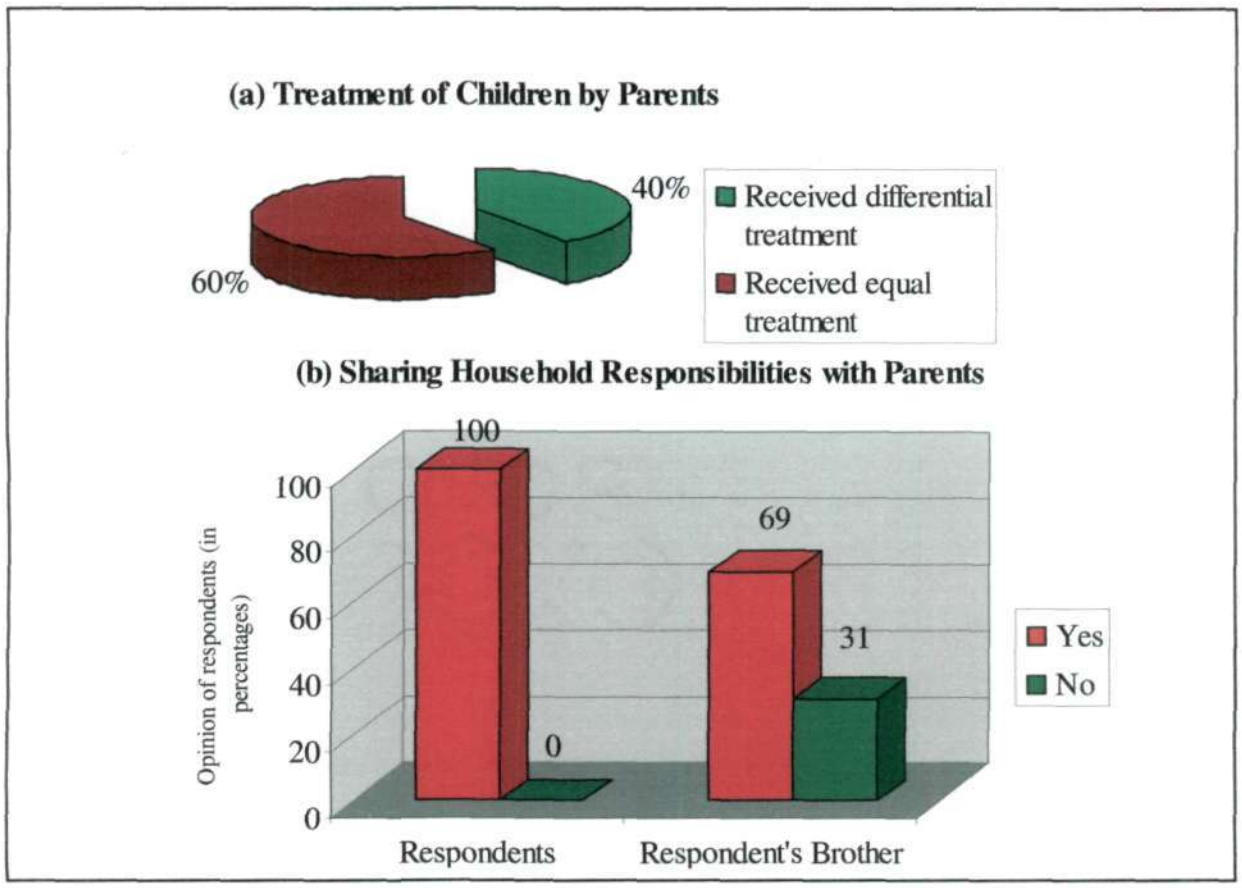


FIGURE 3.2: RELATIONSHIP OF RESPONDENTS WITH PARENTS



Source: Field Survey

The table 3.1 indicates that majority of the respondents belong to the age group of 13-15 years (46 per cent), followed by the age group 17-19 years (32 per cent) and 11-13 years (20 per cent). For easy understanding the data is also shown in fig. 3.1 (a). In sum, we can say that majority of respondents belong to the age group of 14-16 years. Therefore, the average age of respondents is 15 years.

Religion:

Religion plays an important role in an individual's life. The religious values acquired during adolescence have a great influence upon his developing personality and character trends. The kind of individual he is, will determine the effect upon his religious attitudes of his changing physical, emotional and social experiences. The attitudes of family towards religion, kind and amount of religious training received during childhood, religious attitudes of peer associates, adult example, influence of secular education and the extent of preoccupation with study work an social activities are some of the variables which affect individual's understanding of religion in his formative years. Religion has controlled persons physically, mentally and socially by assigning social obligations and controlling them through different religious ideas.

The religious background of the respondents is given in table 3.2 and fig. 3.1 (b). A perusal of this table and figure shows that 58 per cent are Hindus, 23 per cent Meiteism, 10 per cent Muslims and 9 per cent Christians. Here, we can conclude that most of the respondents are Hindus.

TABLE NO. 3.2

RELIGIOUS BACKGROUND OF RESPONDENTS

Religion	No. of respondents	Percentage
Hinduism	58	23
Meiteism	23	58
Christians	9	9
Islam	10	10
Total	**100**	**100**

Source: Field Survey

Educational Background:

Education is the key aspect for the empowerment of adolescent girls. There is a growing consensus now that education irrespective of who receive it contributes to development. Higher the education, higher would be the possibilities of raising income, improve health and quality of life. Education is also a powerful way of ensuring girls and women equal access to knowledge, skills, jobs and participation in society.

However, in a poor socially disadvantaged family where discrimination is high, favouring education for boys over girls going to school can be seen. Heavy workloads at home also keep most girls out of school. According to a report, even in school, girls faced discrimination from teachers, in textbooks, in tasks and from their male classmates. Inferior education lowers a girl's self-esteem, her employment opportunities and her participation in society. Numerous studies have revealed that a girl's disadvantages are often passed on to the next generation later in life.

The educational structure of the respondents is given in table 3.3 and also fig. 3.1 (c). It shows that all the respondents are educated. A perusal of this table shows that about 51 per cent got education up to high school level, followed by secondary (31per cent) and under graduates (18 per cent). Thus, we can see that all the respondents are educated and most of them are educated up to high school level.

TABLE NO. 3.3

EDUCATIONAL BACKGROUND OF RESPONDENTS

Educational structure	**No. of respondents**	**Percentage**
Primary	-	
High school	51	51
Secondary	31	31
Under graduates	18	18
Total	**100**	**100**

Source: Field Survey

Parents' Treatment towards Children:

Gender discrimination is prevalent everywhere. In several parts of the world due to economic pressures and traditional beliefs, there is preference for male child. In India, boys unlike girls bring dowry to the household. Girls require the payment of dowry and parents fear financial burden of their bringing up and marriage. Because of this, some girls are rejected even before birth. Thus, there is imbalance in sex ratio. A new study estimates that 10 million girls are missing from India's population since 1985 [2]. The deaths of young girls in India exceed those of young boys by almost one-third of a million every year [3]. Every sixth infant death is especially due to gender discrimination.

In a poor family, girls get inferior food, less health care and less nurturing than her brothers do. A girl's childhood is terminated early because of the household work responsibilities. When her brother is busy playing, she is always taught to help her mother in the household chores so that she will not face difficulties at her husband's house.

In order to know about parent's treatment towards their children, information is gathered from respondents and is being tabulated in table 3.4 and also shown in fig. 3.2 (a).

TABLE NO. 3.4

TREATMENT OF CHILDREN BY PARENTS

Responses	**No. of respondents**	**Percentage**
Received Differential treatment	40	40
Received Equal treatment	60	60
Total	100	100

Source: Field Survey

The above table makes it clear that more than half of the respondents (60 per cent) received equal treatment from parents. However, we can also see a large percentage of them about 40 per cent received differential treatment from their parents.

This proves the fact that gender discrimination is still prevalent in the Manipuri society. This is also despite the fact that all the respondents are educated, they cannot raise their voice against their parents and this discrimination because they take it as natural and are maintaining the tradition that has been carrying on since earlier times. Thus, the result clearly shows that adolescent girls in Manipur need to go a long way to see themselves as empowered, despite the earlier mentioned assumption that education is one of the key to empowerment.

Sharing Household Responsibilities with Parents:

TABLE NO. 3.5

SHARING HOUSEHOLD RESPONSIBILITIES WITH PARENTS

Responses	No. of respondents	Percentage	Respondents' brother	Percentage
Yes	100	100	69	69
No	-	-	31	31
Total	100	100	100	100

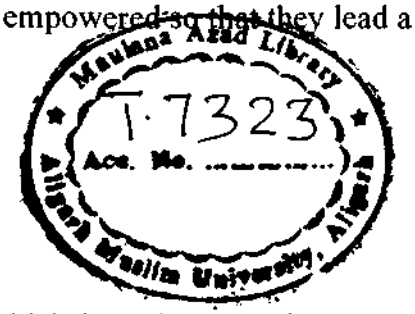
Source: Field Survey

Information about respondents and respondents' brothers sharing in household responsibilities with parents is gathered from respondents and tabulated in table 3.5 and fig. 3.2 (b). A perusal of this table shows that all the respondents 100 per cent helped their parents in the household responsibilities. It is also interesting to know that more than half of their brothers of the respondents also helped their parents in the household responsibilities.

Thus, it is clear that both the respondents and their brothers help their parents in the household responsibilities, but it is also true that while all the respondents help their parents, only 69 per cent of respondents' brothers' help in the household responsibilities, 31 per cent of respondents' brothers help nothing. Despite this existing discrimination, respondents are not complaining and enjoy doing the household chores as their duty.

This result indicates that all the respondents are not complaining as they are engaged in helping their parents and at the same time all of them are studying. However, looking in another way, this may hamper their growth in terms of education in their later years because being busy they may get tired and their interests in studying may deteriorate thus barring them from getting many benefits

in future. So, adolescent girls in Manipur need to be empowered so that they lead a life free of any problems.



Health Problems during Menstruation

Age at First Menstruation:

Adolescence in girls is a turbulent period, which includes stressful events like menarche, considered as a landmark of female puberty [4]. Menstruation is often marked as a potential entry into sexual relationships and reproduction. Menarche (the onset of menstruation) in adolescent girls occurs at an average twelve to thirteen years of age, although she may mature considerably earlier or later (9 to 18 years in an extreme range). There is controversy over change in age at menarche. Girls start menstruating earlier today than in former generations because of proper nutrition and health care [5].

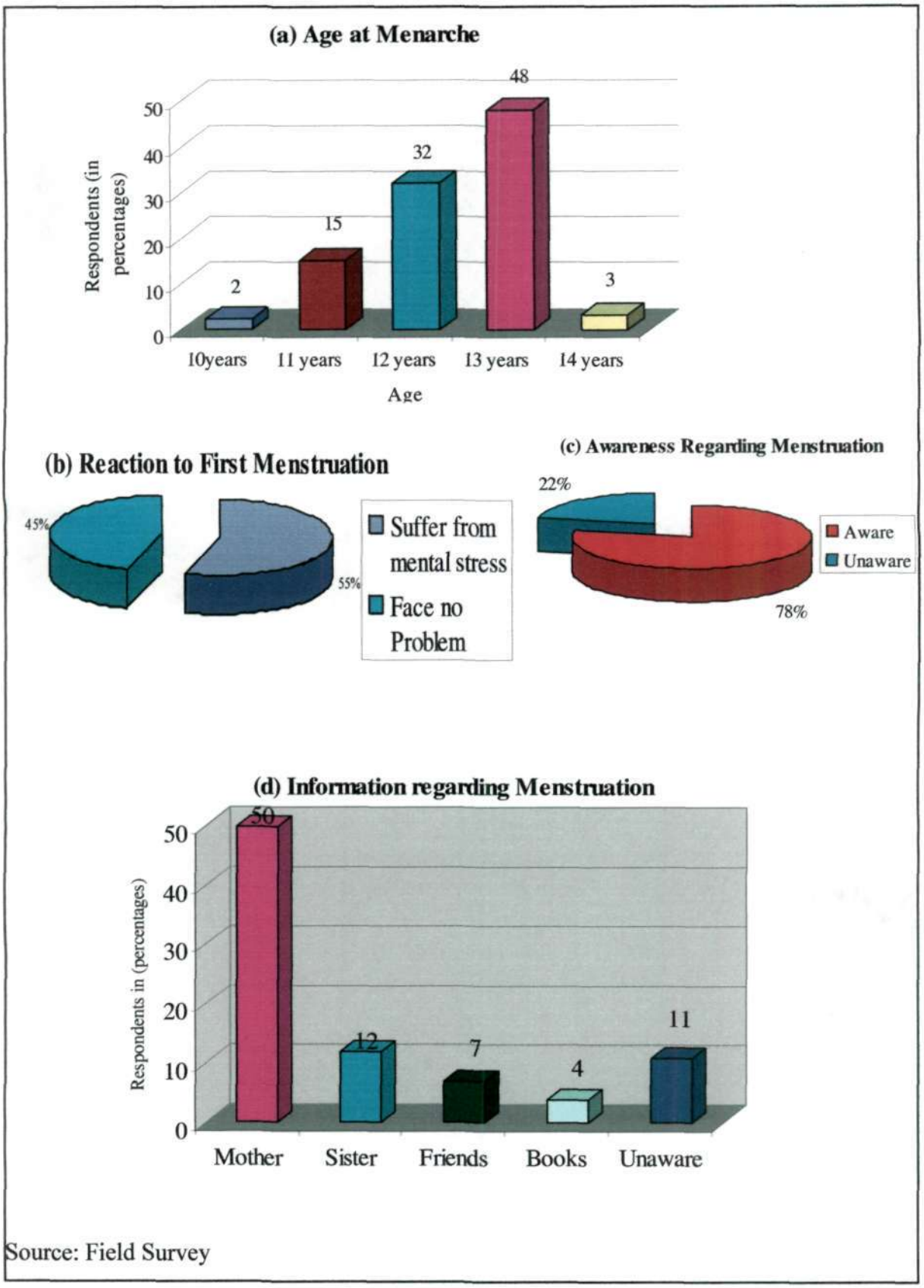
TABLE NO. 3.6

AGE AT MENARCHE OF RESPONDENTS

Age	No. of respondents	Percentage
10	2	2
11	15	15
12	32	32
13	48	48
14	3	3
Total	**100**	**100**

Source: Field Survey

FIGURE 3.3: PROFILE OF THE RESPONDENTS REGARDING MENSTRUATION



Source: Field Survey

Table 3.6 and fig. 3.3 (a) indicates that maximum number of girls (48 per cent) experiences first menstruation at the age of 13 years, 32 per cent at 12 years, 15 per cent at 11 years, 3 per cent at 14 years and 2 per cent at 10 years. To conclude it can be said that the age of menstruating girls' ranges from 10-14 years with maximum number of girls at 13 years of age.

Reaction to First Menstruation:

Information regarding respondents' reaction to first menstruation is collected and tabulated in table 3.7 and fig. 3.3 (b).

TABLE NO. 3.7

REACTION TO FIRST MENSTRUATION OF RESPONDENTS

Responses	**No. of respondents**	**Percentage**
Suffer from mental stress	55	55
Face no problem	45	45
Total	**100**	**100**

Source: Field Survey

The table clearly shows that more than half of young girls 55 per cent of them complained to suffer from discomfort, disgust and were even scared to see blood flow for the first time, whereas 45 per cent of them have no any menstruation related syndromes. The result shows that most of the girls are given prior knowledge about menstruation. Therefore, they do not suffer from much stress whereas a good number of girls do suffer because of lack of information.

Awareness Regarding Menstruation:

With lack of information, first menstrual flow can be terrifying to a young girl. In most parts of India, first menstrual experience is often a traumatic and very negative experience for young girls [6]. Negative responses such as shame, fear, anxiety and depression are most common. It has been found that menarche emerged as the strongest predictor of depression and anxiety among adolescent girls[7]. Most young girls suffered from physical discomforts, increased emotionally and mood changes and disruption of activities and social life. Some accepted menstruation in a natural way because they have been taught about it. Thus, the reaction to menstruation depends upon awareness and knowledge about it. According to a study, young girls with no previous knowledge about menstruation felt more scared, uncomfortable, indifferent or disgusted at menarche[8]. It is therefore, necessary to give young girls the knowledge and information about menstruation prior to menarche.

Information related to awareness about menstruation is collected from respondents and tabulated in table 3.8 and fig. 3.3 (c).

TABLE NO. 3.8

AWARENESS REGARDING MENSTRUATION OF RESPONDENTS

Awareness	**No. of respondents**	**Percentage**
Aware	78	78
Unaware	22	22
Total	**100**	**100**

Source: Field Survey

It clearly shows that awareness about menstruation prior to its onset is high. Maximum 78 per cent of the respondents have knowledge about menstruation whereas the rest 22 per cent respondents have no previous knowledge and thus become scared at the sight of blood. Their problems need to be seriously addressed. In sum, we can say that majority of respondents are aware of menstruation prior to its onset. This shows that they are having the required information, which is very important, as adolescence is a period of change viz., physical, mental etc.

Source of Information Regarding Menstruation:

Source of information regarding menstruation is collected from respondents and tabulated in table 3.9 and also shown in fig. 3.3 (d).

TABLE NO. 3.9

SOURCE OF INFORMATION REGARDING MENSTRUATION OF RESPONDENTS

Source	No. of respondents	Percentage
Mother	51	51
Sister	14	14
Friends	9	9
Books	4	4
Unaware	22	22
Total	**100**	**100**

Source: Field Survey

A perusal of this table shows that majority of the girls i.e., 51 percent got the first information from their mother. The other major informants about menstruation are sisters (14 percent) and friends (9 percent). Some respondents 4 percent who are very shy to speak about menstruation from books prior to menstruation.

Thus, it can be concluded that parents play the most important role of giving knowledge regarding menstruation to the young girls and the least source are their friends. It is important to spread awareness among the young girls regarding the onset of menstruation so that they do not suffer from any shock or stress.

Practices during Menstruation:

Several traditional beliefs, misconceptions and practices about menstruation makes the young girl depressed and stressed which may lead to health problems and may hamper her development. Unsafe practices during menstruation lead to reproductive tract infections and other reproductive health problems. In a study, it is found that of the 380 women for investigation; only 2.9 per cent are using sanitary napkins while the rest either used old or worn clothes [9]. It is crucial to examine the issues related to menstrual practices among adolescent girls in their socio-cultural context, and to understand the association of menstrual practices with reproductive morbidity [10].

In this present study, relevant information about practices during menstruation about respondents is collected and tabulated in table 3.10 and fig. 3.4 (a).

It is clear from the above table, that maximum number of young girls (57 per cent) used readymade sanitary napkins/pads during menstruation and 43 per cent respondents used cloth, the traditional way. One reason is that most of the respondents are still unaware of the consequences of using unhygienic cloth during menstruation. This problem needs to be seriously dealt with. Another

reason is the high cost of sanitary pads which some of the girls cannot afford to buy one. Very unhygienic practice that can be seen is that some of the respondents reused the old cloth. The practice is to wash the used cloth. The practice is to wash the used cloth with detergent and keep it in a secret place for next menstruation. Sometimes to avoid from the sight of male members in the family, they kept it in a very unhygienic place, which may eventually create gynaecological problems like urinary tract infections to the young girl.

TABLE NO. 3.10

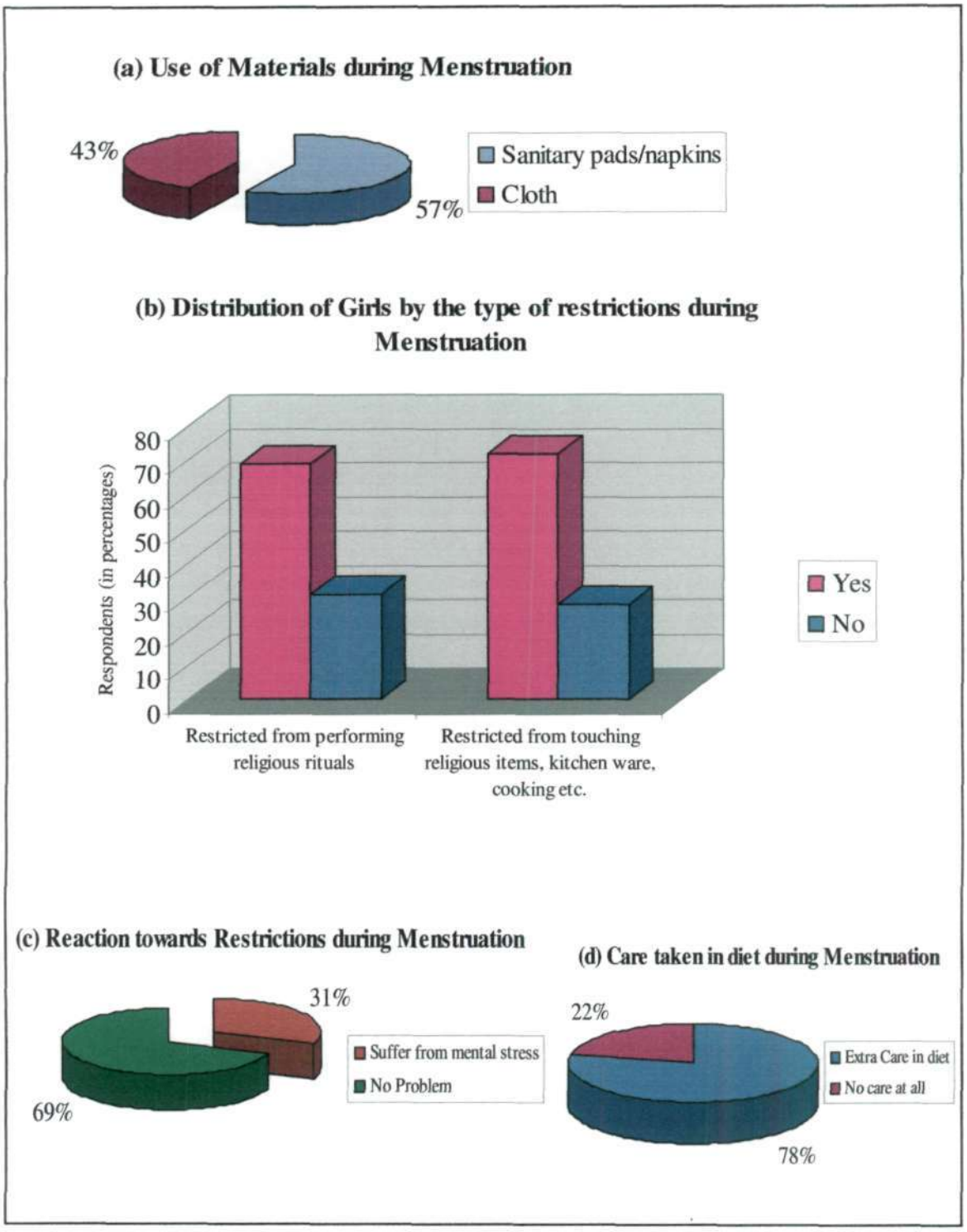
USE OF MATERIAL DURING MENSTRUATION OF RESPONDENTS

Material Used	**No. of respondents**	**Percentage**
Sanitary pads/napkins	57	57
Cloth	43	43
Others	0	0
Total	**100**	**100**

Source: Field Survey

One important thing that is also required to check is that girls should be made free from all the tensions or uncomfortable situation that they faced during menstruation so that they can get rid of all the health problems specially gynaecological one that may arise because of lack of information, carelessness etc

FIGURE 3.4: MENSTRUAL PRACTICES AND RESTRICTIONS DURING MENSTRUATION



Source: Field Survey

Types of Restrictions Faced by Respondents during Menstruation:

In India, in the past, even mere mention of menstruation has been a taboo and even today, the cultural and social influences appear to be a hurdle for the advancement of knowledge of the subject [11]. The traditional beliefs and restrictions may make the girl stressed and may hamper her overall development. The young girls have several restrictions to be followed during menstruation. They are not allowed to perform religious rituals, not allowed to touch religious items and also restricted from cooking for the family. Some are even restricted from washing hair, taking a bath etc. Such restrictions make the condition of the young girls worse because they have to suffer from embarrassment when all the family members including male members come to know about her situation.

As far as performing religious rituals during menstruation is concern, table 3.11 and fig. 3.4 (b) indicates that 69 per cent of the respondents are restricted from performing any religious rituals while 31 per cent of respondents do not have any such problems.

TABLE NO. 3.11

DISTRIBUTION OF RESPONDENTS BY THE TYPE OF RESTRICTIONS FACED BY THEM DURING MENSTRUATION

Type of restrictions	Response	No. of respondents	Percentage
Restricted from performing religious rituals	Yes	69	69
	No	31	31
Restricted from touching religious items, kitchen ware, cooking etc.	Yes	72	72
	No	28	28
	Total	**100**	**100**

Source: Field Survey

It is also clear that majority of the respondents 72 per cent are also restricted from touching religious items, kitchenware, cooking etc. About 28 per cent of the respondents do not face such kind of restrictions.

So, it can be said that even in this age, traditional beliefs and practices are still followed. This is because majority of respondents are still restricted from cooking, touching religious items, performing religious rituals etc., during those five days of menstruation. Thus it is found that during menstruation girls are treated as untouchables but the girls would not fight against this ill-treatment and follow the traditional way of life.

Reaction Towards the Restrictions Faced During Menstruation:

A perusal of table 3.12 and fig. 3.4 (c) clearly shows that majority of young girls 69 per cent agrees with the traditional beliefs and practices so do not faced any problem. It is unbelievable that they are ready to suffer when they are treated as untouchables. One reason for this is because they are happily following these beliefs and practices that have been going on since long.

Whereas 31 per cent of respondents suffer from mental stress because of the restrictions they face during menstruation. They can do nothing but only to follow and suffer. This shows these girls cannot open even their feelings.

Several young girls' condition becomes worse because of certain restrictions during menstruation. When they are restricted from performing religious rituals items, restricted from cooking, everybody in the family come to know about it. The most embarrassing situation for them is when the male members of the family also come to know about it. This embarrassing situation is said to be most miserable and painful. There are also times, when a male member happens to see by mistake menstrual cloth; this situation also makes them stressed.

TABLE NO. 3.12

REACTION TOWARDS RESTRICTIONS DURING MENSTRUATION OF RESPONDENTS

Reactions of respondents	No. of respondents	Percentage
Suffer from mental stress	31	31
No problem	69	69
Total	**100**	**100**

Source: Field Survey

Care taken in Diet during Menstruation:

Information on respondents' care taken in diet during menstruation is collected and tabulated in table 3.14 and fig. 3.4 (d). 22 per cent respondents do not restrict eating some food items which some think may not be good for their health if consumed during menstruation.

TABLE NO. 3.13

CARE TAKEN IN DIET DURING MENSTRUATION OF RESPONDENTS

Care in diet during menstruation	No. of respondents	Percentage
Extra care in diet	78	78
No care at all	22	22
Total	**100**	**100**

Source: Field Survey

However it is also clear that maximum number of respondents 78 per cent has taken care in diet during menstruation thus following the restrictions from eating different types of fruits and vegetables during menstruation as a result of certain myths they believe, such as they are restricted from eating sour fruits, brinjal, coriander, banana flower etc.[12]. The reason for not consuming these mention things is that their complexion will become worse if they happen to eat these things during menstruation.

The consequences for this may be just the opposite. Young girls may not be getting the necessary food intake and the care they should take specially during menstruation because of the misconception and so they may end up being anaemic.

Health Problems Faced during Menstruation:

Numbers of young girls suffer from gynecological problems such as [13].

1. Amenorrhoea (no menses),
2. Oligomenorrhoea (infrequent menses),
3. Mehorrhagia (too much bleeding at the time of menses),
4. Metrorrhagia (too frequent episodes of bleeding),
5. Dysmenorrhoea (painful periods)

Dysmenorrhoea, which means painful periods, is the menstrual problem; this is suffered by most young girls in India. In a study in Mumbai, nearly 55 per cent of the girls are found to be suffering from dysmenorrhoea [14].

A perusal of table no. 3.14 and fig. 3.5 (a) show that the major problem faced by the respondents during menstruation is abdominal pain, which is reported by 53 per cent of respondents, while 12 per cent of respondents complain of irregular menses, 6 per cent of respondents, says they suffers from both the

problems. The rest 29 per cent says they do not suffer from any health or gynaecological problems regarding menstruation.

TABLE NO. 3.14

HEALTH PROBLEMS FACED DURING MENSTRUATION OF RESPONDENTS

Problems faced	**No. of respondents**	**Percentage**
Menstrual pain	53	53
Irregular menses	12	12
Both	15	15
Faced no problem	20	20
Total	**100**	**100**

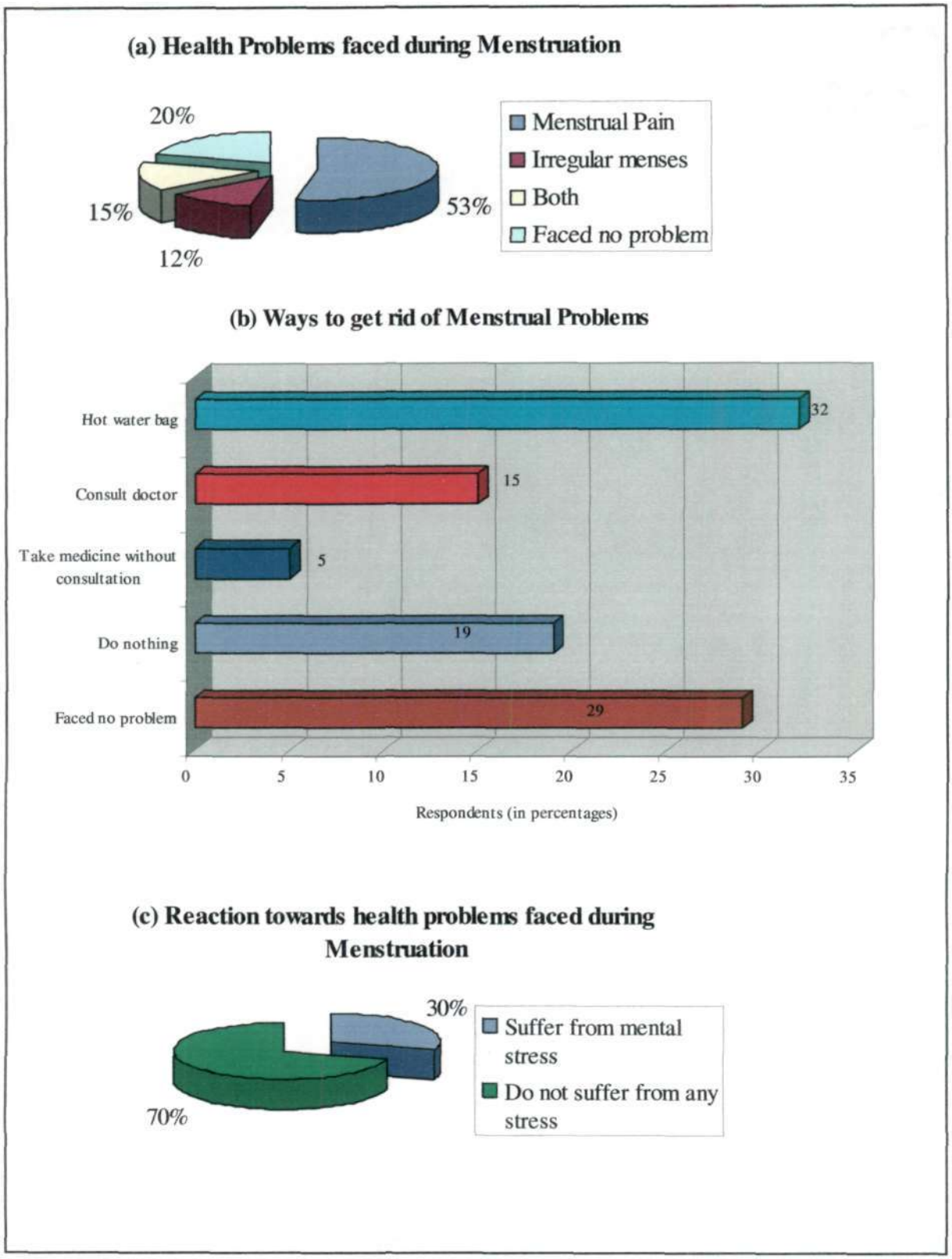
Source: Field Survey

Ways to Get Rid of Menstrual Problems:

One study shows that women who are encouraged to understand and appreciate the role of women in society, experience less problems regarding menstruation. There are reports of decreased menstrual symptomatology [15]. Family and friends may be helpful to deal with the problems.

Looking into the way the respondents respond to their menstrual problem that is shown in table 3.15 and fig. 3.5 (b), we can see their hesitation to consult a doctor even a family doctor regarding their health problems. It can be a difficult social challenge for the doctor as well.

FIGURE 3.5: HEALTH PROBLEMS FACED DURING MENSTRUATION AND RESPONDENTS' REACTION TOWARDS IT.



Source: Field Survey

TABLE NO. 3.15

WAYS TO GET RID OF HEALTH PROBLEMS FACED DURING MENSTRUATION OF RESPONDENTS

Ways used	**No. of respondents**	**Percentage**
Hot water bag	32	32
Consult Doctor	15	15
Take medicine without consultation	5	5
Do nothing	19	19
Faced no problem	29	29
Total	**100**	**100**

Source: Field Survey

Further, only a few 15 per cent of girls consulted doctor regarding their menstrual problems while most of them 32 per cent used hot water bag to get rid of abdominal pain, 5 per cent of them take medicine on their own even without consulting doctor to get rid of the pain which could lead to a greater problem then they are facing and 15 per cent respondents did nothing to solve their problems. In this situation, confidentiality should be maintained and the doctor should have an established policy regarding consent for treatment of young girls, explained to all adolescent patients and their parents.

Reaction Towards Health Problems Faced during Menstruation:

Information relevant to respondents' reaction towards health problems faced during menstruation is collected and tabulated in table 3.16 and fig. 3.5(c).

TABLE NO. 3.16

REACTIONS TOWARDS HEALTH PROBLEMS FACED BY RESPONDENTS DURING MENSTRUATION

Reaction of Respondents	**No. of respondents**	**Percentage**
Suffer from mental stress	30	30
Do not suffer from any stress	70	70
Total	**100**	**100**

Source: Field Survey

A perusal of table no. 3.16 clearly shows that 30 per cent of the respondents suffer from mental stress that may become worse and dangerous if not dealt with on time, while a large number of respondents 70 per cent do not suffer from any stress because of the problem of menstrual pain and irregular menses.

Physical Change during Adolescence

Awareness Regarding Physical Change:

Early adolescence is a time of rapid physical development and deep emotional changes. Most young girls often lack knowledge on the various changes that has taken place with her, so they face overwhelming problems. The physical changes for young girls include menstrual period, growth of underarm, body and pubic hair. They may be worried about these changes and how they are looked at by others. The changes can be more worrying to some girls especially to those who are shy and who do not like to ask questions. Young people of this age began to think and feel differently. Relationship with friends started to be much closed while relationships within the family change. They become very emotional and

conscious about their appearance. That is why a pimple or being ahead or behind a classmate in physical growth can be so stressful to the girl's emotions.

Researchers in their study have observed that adolescent girls experienced greater stress and are twice as likely to be depressed, attempt suicide four or five times as often, as compared to boys [16]. The reason for girl's depression has been found to be linked to negative feelings about their bodies and appearances.

In a study on the health of adolescent girls, it is found that although majority of the young girls who are having healthy and strong mental health exhibited depressive symptoms. It is also reported that these girls lack a source of support during times when they felt depressed or stressed [17]. However, parents remained a source of support for the majority of girls.

Information relating to respondents' awareness on physical changes is given in 3.17.

TABLE NO. 3.17

AWARENESS OF RESPONDENTS REGARDING PHYSICAL CHANGE

Responses	No. of respondents	Percentage
Aware	45	45
Unaware	55	55
Total	**100**	**100**

Source: Field Survey

A perusal of table 3.17 and fig. 3.6 (a) indicates that 45 per cent of respondents are aware of the physical changes whereas 55 per cent respondents are unaware of the changes that have taken place. This lack of awareness may have serious health consequences for example the girls may go into depression. At this situation, it is the responsibility of the parents to provide advice, sympathy and comfort to the young girls so that this stage of storm and stress will be passed away smoothly.

Source of Information Regarding Physical Change of Respondents:

It is clear in table 3.18 and fig. 3.6 (b) that 21 per cent of respondents regarded their mother as the main source of information about physical change, 14 per cent from sisters while 8 per cent respondents got the information from friends, and 2 per cent from books.

TABLE NO. 3.18

SOURCE OF INFORMATION REGARDING PHYSICAL CHANGE OF RESPONDENTS

Source of information	No. of respondents	Percentage
Mother	21	21
Friends	8	8
Sisters	14	14
Books	2	2
Unaware of change	55	55
Total	**100**	**100**

Source: Field Survey

Thus, to conclude we can say that most of respondents got information about physical changes mostly from their mother that shows the love, support and care towards their daughters. However, it is revealed that majority of the respondents i.e., more than half of the respondents were unaware about the physical changes in their body that needs to be seriously dealt with.

Reaction of Respondents towards Physical changes during Adolescence:

Relevant information about respondents' reaction towards physical change is collected and tabulated in 3.19 and fig. 3.6 (c). The table reveals that more than half of the respondents 59 per cent suffer from mental stress because of the changes that takes place in their body. This problem may worsen if they are not

provided the information they needed. All these may adversely affect the psychological development of adolescents.

TABLE NO. 3.19

REACTION OF RESPOPNDENTS TOWARDS PHYSICAL CHANGE

Reaction of Respondents	No. of respondents	Percentage
Suffer from mental stress	59	59
Faced no problem	41	41
Total	**100**	**100**

Source: Field Survey

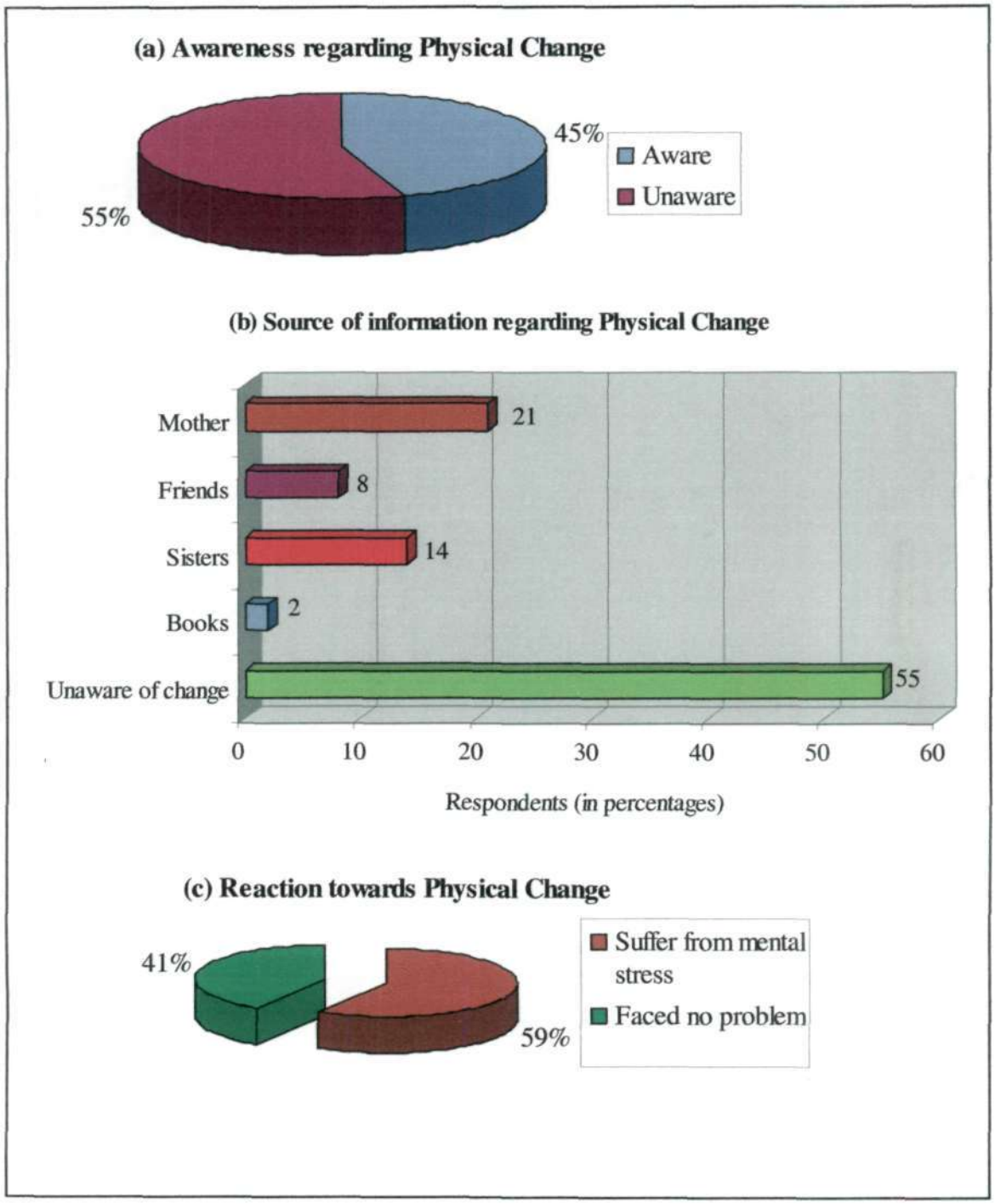
The remaining 41 per cent of the respondents face no problem and also do not experienced any such emotional problems because some have prior knowledge about the changes taking place while some think it natural.

Other problems of Adolescent Girls

Awareness of Respondents Regarding Contraception, Pregnancy and Childbirth:

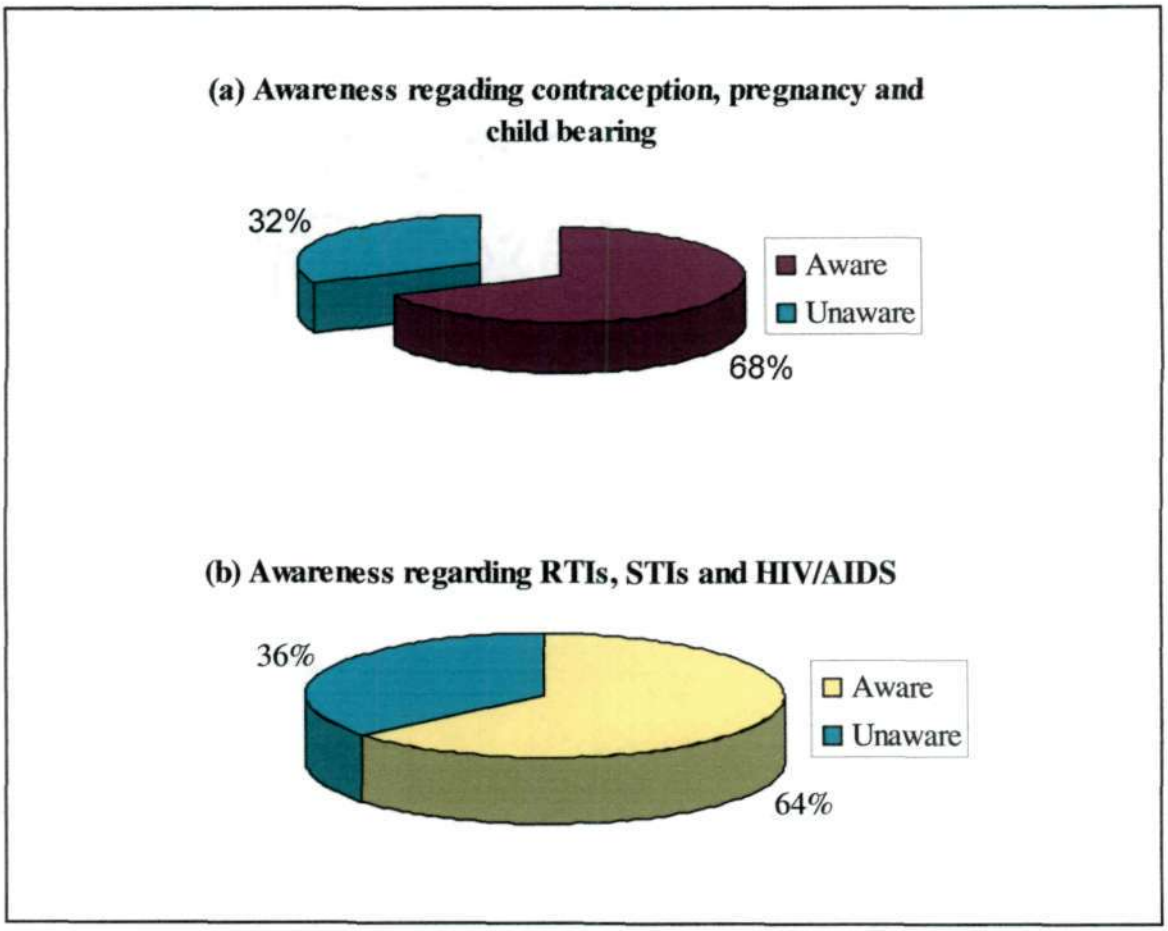
A look in table 3.20 and fig. 3.7 (a) shows that majority that is 68 per cent of the respondents are aware about the various available contraception, pregnancy and child bearing. However, though majority of the respondents are having awareness, 32 per cent are not aware at all and this is a matter of great concern.

FIGURE 3.6: AWARENESS AND REACTION OF RESPONDENTS TOWARDS PHYSICAL CHANGE



Source: Field Survey.

FIGURE 3.7: AWARENESS OF THE RESPONDENTS REGARDING CONTRACEPTION, PREGNANCY, CHILD BEARING, RTIs, STDs AND HIV/AIDS



Source: Field Survey.

TABLE NO. 3.20

AWARENESS OF RESPONDENTS REGARDING CONTRACEPTION, PREGNANCY AND CHILDBIRTH

Responses	No. of respondents	Percentage
Aware	68	68
Unaware	32	32
Total	**100**	**100**

Source: Field Survey

So, this result reveals that good number of adolescent girls in Manipur are still ignorant of the information which are regarded important or a must before they move into a stage of life i.e., reproduction so as to protect themselves from various risk-taking behaviours and reproductive health problems which if not dealt with in time may last a lifetime. Risk-taking behaviour is considered by some to be a normal part of adolescent development. During adolescence, young people experience great and rapid changes – in their bodies, concerns, relationships and roles in society. They also take on more responsibility for their health and well being. According to UNAIDS[18], adolescence and youth are times of discovery, emerging feelings, exploration of new behaviour and relationships. Sexual behaviour, an important part of this can involve risks; the same is true of experimentation with drugs- legal and illegal. Experimentation with sexual behaviour, smoking, alcohol and drug use, however, represents an adolescent's willful decision to engage in activities associated with risks of health or life threatening outcomes. In the opinion of Green[19], adolescents gain more independence and begin to experiment with new behaviours; some of which placed them at risk for potentially negative health consequences.

Awareness Regarding RTIs, STDs and HIV/AIDS:

According to NACO[20], in India, people in the age group of 15-29 years comprise almost 25 percent of the country's population; however, they account for 31 percent of the AIDS burden. This clearly indicates that young people are not only at high risk of contracting HIV infection but already constitutes a significant percentage of people living with HIV/AIDS. Gender imbalances, societal norms and economic dependence contribute to this risk. Lack of access to correct information, tendency to experiment and an environment which makes discussing issues around sexuality a taboo adds to their vulnerability to the devastating AIDS epidemic[21]. Young women are said to be biologically more vulnerable to HIV infection than young men – a situation aggravated by their lack of access to information on HIV and even lesser power to exercise control over their sexual lives. Early marriage also poses special risks to young people, particularly women. This is especially relevant for India, where a majority of the girls are married off by the time they are 18 years of age.

Though National AIDS Control Programme (NACP) was launched in India to educate people about the means by which HIV is transmitted and the ways to prevent it, there is enough evidence to prove that there is a lack of awareness among the people about HIV[22, 23].

The gap in the knowledge among people about HIV can be attributed to the failure of awareness programmes, to take into consideration the socio-cultural peculiarities of a country like India. In India there exists widespread poverty, illiteracy, social inequalities based on caste, poor nutritional and health status of the population, prevalence of sexually transmitted diseases[24], reproductive tract infections and virtual lack of public hygiene[25]. Furthermore, epidemiology of HIV is complicated in India due to high labour migration and mobility in search of employment from economically backward to more advanced regions.

TABLE NO. 3.21

AWARENESS REGARDING RTIs, STDs and HIV/AIDS

Responses	No. of respondents	Percentage
Aware	64	64
Unaware	36	36
Total	**100**	**100**

Source: Field Survey

A perusal of table 3.21 and fig. 3.7 (b) shows that 64 per cent respondents have knowledge regarding RTIs, STIs and HIV/AIDS while 36 per cent are unaware of it. Though the awareness level is high, the remaining group who do not have idea on the said terms may prove to be a growing threat for the spread of STDs, RTIs and HIV/AIDS.

As discussed earlier, the social system in Manipur is such that anything regarding matters of sex and drug use is neither spoken loudly nor discussed in public. Thus, stigma is attached to HIV/AIDS because of its association with sexual transmission and intravenous drug use. AIDS education has not yet been 'fully'[26] included in the formal curriculum in schools and colleges while the reported proportion of HIV positive among the school and college going age group, 11-30 years is 48.92 percent[27]. The topic of AIDS has been introduced in schools as a part of biology lessons since few years. However, teachers used to skip and ask the students to read on their own. No systematic AIDS awareness programme exists as yet in the state of Manipur for students[28]. The lack of communication about HIV/AIDS regarding sexual transmission and drug use is likely to be conducive to the spread of HIV infection in Manipur. Further, the youth in Manipur, because of the instability of the social situation and other factors, with various disruptions in their normal day-to-day functioning have added stressors in their lives. Besides ethnic conflicts, insurgency, political

instability etc., there are also frequent strikes and boycotts which greatly affect the social and economic life of the common people. All these factors interact with one another and play an important role in the healthy development of an individual.

To sum up, adolescent girls in Manipur need to go a long way to see them as empowered. This is despite the various available Governmental Policies and Programmes in India. The finding shows that girls are not benefited much by these said policies and programmes.

As preference for a male child is prevalent in Manipuri society, discrimination against girls can be seen in some form or the other. Young girls reveal getting differential treatment from their parents as compared to their brothers. It is also interesting to know that majority of girls are aware of the onset of menstruation and mother plays an important role in giving the said information. But there are also girls, who lack knowledge on the said thing, were frightened at the sight of blood for the first time and they do suffer from stress. Further, it is shocking to know that some girls are found following unhygienic practices and certain myths during menstruation which consequently may increase susceptibility to various infections. Another shocking revelation is that more than half of the girls are unaware and uninformed about the physical changes. As discussion on sexuality is absent in Manipuri society, we can see clearly the communication gap between the parents and their children. So, young girls are not prepared mentally for the physical changes and thus suffer from stress. This deeply affected their interests, their social behaviour and the quality of their affective life, which may deteriorate their health condition and may have long lasting effect. It also come to light that girls have knowledge on contraception, pregnancy, and childbirth, RTIs, STIs, and HIV/AIDS, etc but still good number of them are ignorant that may prove to be risky for their future health, if their needs are not addressed properly.

References

1. Sohoni, N.K, (1995), The Burden of Girlhood: A Global Inquiry into the Status of Girls, Third Party Publishing Company, California.

2. IDRC, (2006-05), India's Missing Daughters: An International Development Research Centre Publications. http://www.idrc.ca/en/ev-95719-201-1-DO_TOPIC.html

3. Ibid.

4. Bansal, R.D and Mehra, M, (1998), Adolescent Girls: An Emerging Priority, Indian Journal of Public Health, 42(1), 1.

5. Bullough, V.L, (1981), Age at Menarche: A Misunderstanding, Science, 213, 365-366.

6. George, A, (1994), It Happens to us: Menstruation as Percieved by Poor Women in Bomba', In J. Gittelsohn, M. E. Bentley, P. J. Pelto, M. Nag, S. Pachauri, A. D Harrison and L. Landman (eds),'Listening to Women Talk About Their Health: Issues and Evidence from India, Ford Foundation and Har Anand, New Delhi, 168-83.

7. Patton, G. C, *et. al.*, (1996), Menarche and Onset of Depression and Anxiety in Victoria, Australia, Journal of Epidemiology and Community Health, 50 (6), 661-66.

8. Rama, Rao.A, (1963), A Study on Menstruation in Adolescents, Journal of Indian Medical Association, 40 (1), 315-19.

9. Gar, Suneela, Nandini Sharma and Ragini Sahay, (2001), Socio-Cultural Aspects of Menstruation in an urban Slum in Delhi, India, Reproductive Health Matters, 9 (17), 16-23.

10. Khanna, Anoop, R.S Goyal and Rahul Bhawsar, (2005), Menstrual Practices and Reproductive Problems: A study of Adolescent Girls in Rajasthan, Journal of Health Management, 7, 1, Sage Publications, New Delhi, Thousand Oaks, London, 91-107.

11. Rama, Rao. A, (1963), A Study on Menstruation in Adolescents, Journal of Indian Medical Association, 40 (1), 15-19, 315-19.

12. Based on Field Survey, 2003-04.

13. Huffman, J. W, (1986), Teenagers' Gynaecological Problems, Medical Aspects of Human Sexuality, 20, 57-61.

14. Vaidya, R. A, *et. al.*, (1998), Menstrual Pattern and Growth of Schoolgirls in Mumbai, Journal of Family Welfare, 44 (1), 66- 72.

15. Brattesani, K and Silverthorne, C. P, (1978), Social Psychological Factors of Menstrual Distress', Journal of Social Psychology, 106, 139-140.

16. Debold, Elizabeth, (1995), Helping Girls Survive the Middle Grades, Principal, 74 (3, January), 23.

17. Schoen, Cathy, *et. al.*, (1997), The Commonwealth Fund Survey of the Health of Adolescent Girls, The Commonwealth Fund, November.

18. UNAIDS, (1999), Report on the Global HIV/AIDS Epidemic. Geneva.

19. Green, L.W, (1999), Health Education's Contributions to Public Health in the Twentieth Century: A Glimpse through Health Promotions Rear View Mirror, in Annual Review of Public Health, 20, 67-88.

20.NACO (not dated): Youth: What Makes Youth Vulnerable? Available at www.nacoonline.org/Quick_Links/Youth, accessed on October 4, 2007.

21. Timothy, R. and Rajan, S.I., (2004), Awareness and Knowledge about HIV/AIDS in India: Evidences from RCH Survey (1998-99) in Demography India, Vol. 33, No. 1: 61-83.

22. Gupta, I. and Mitra, A., (1998), Knowledge of HIV/AIDS among Migrants in Delhi Slum, Working Paper: E/195/98, Institute of Economic Growth, New Delhi.

24. Sureender, S. et al., (1997), Knowledge and Attitude of School Children about HIV/AIDS: Evidences from Rural Maharashtra, Indian Journal of Social Work, 58 (4):599-615.

25. Gaitonde, I.R., (2001), A Thief in the Night: Understanding AIDS, Chennai: East West Books.

26. The Week, (2002), December 22: 28-30.

27. Manipur AIDS Control Society, Annual Report, (2006-2007).

28. Epidemiological Report, (2008), the Manipur State AIDS Control Society.

29. NACO, (2005), Rapid Needs Assessment of HIV Programme Needs in Five North Eastern States of India, A Joint Initiative of NACO, AusAID, UNAIDS.

CHAPTER IV

EMPOWERING WOMEN FOR SOCIAL DEVELOPMENT IN RESPECT TO HEALTH

CHAPTER IV

EMPOWERING WOMEN FOR SOCIAL DEVELOPMENT IN RESPECT TO HEALTH

The present chapter is an attempt to examine how far women of Manipur are benefited from the Governmental Policies and Programmes by looking into their socioeconomic political background, their health and reproductive health needs, level of awareness regarding contraception and decision-making.

Improving women's health matters to women, to their families, communities and societies at large. Good health of women is vital for their life and well-being and their ability to participate in all areas of public and private life. Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives.

A survey of selected areas of Manipur is carried out in order to explore the empowerment of women in regards to their health. The data thus collected and its interpretations are being given as under:

Results and Discussion

Socio-Economic Profile of Respondents

Socioeconomic status is regarded a major determinant of health. Family with low socioeconomic status is associated with worst health outcomes. In such poverty stricken family, women are least likely to receive or utilise the available health-care services. To describe the socio-economic profile of respondents, various aspects related to their age, religion, marital status, age at marriage, education, husbands' background, employment etc are being analysed here.

Age:

Age is said to be an important variable in determining a women's status. Women's

health needs vary in different periods of their life. A look into women's health status reveals that female mortality is high up to the age of 35 years. The important reason is their socio-economic cultural roles in the society such as the preference for sons, and consequently bias against daughters, and the 'triple burden' placed on young women – reproduction, domestic work and productive labour. In India, the existing social norms prescribed that only adults can participate in decision – making in the family as well as the society. The right to vote, marriage, inheritance of property etc is all controlled by age.

In the selected sample for study, ever married women in the reproductive age groups are included in order to have a thorough investigation. It can be seen in the following table no. 4.1 and fig. 4.1 (a), that most of the respondents about 32.33 per cent belong to the age group 25-29 years followed by 30-34 years (23.67 per cent), 35-39 years (14 per cent), 40-44 years (11.67 per cent), 20-24 years (9.33 per cent), 45-49 years (6.67 per cent) and the least number of respondents (2.33 per cent) belong to the age group 15-19 years.

It can be concluded that majority of the respondents belongs to the age group of 25-29 years. Thus, the average age of the respondents is 27 years.

TABLE NO. 4.1

AGE STRUCTURE OF RESPONDENTS

Age group	No. of respondents	Percentage
15 – 19	7	2.33
20 – 24	28	9.33
25 – 29	97	32.33
30 – 34	71	23.67
35 – 39	42	14.00
40 – 44	35	11.67
45 – 49	20	6.67
Total	**300**	**100**

Source: Field Survey

Religion

Of all the informal means of social control, religion plays an important role in an individual's life. If deeply imbedded in one's personality, it is more important in maintaining effective social control than all the formal means employed by the Government like the police, courts and all other such measures that need lots of finance. Generally, every society has its own social norms and practices, which are based on religion. The believers of all religion look at women as an instrument to contribute to the pleasure and happiness of man. Religion preaches that a woman can attain name and fame only by serving her husband. In India, Hinduism is a religion followed by majority of the people. It is said to be a complex religion that plays a crucial role in many Indian women's life. In various ancient texts, women were generally equated with the Shudras and were described as that of sinful birth. Religion is assumed as another major factor that influenced the educational and economic participation of women in a society. Manipuri women mainly in the valley, are also governed by the norms and practices prescribed by the religion they believed. In Manipur, there are no restrictions on the participation of womenfolk in the religious ceremonies.

A perusal of this table 4.2 and fig. 4.1 (c) shows that majority of respondents 70 per cent belong to Hinduism followed by 20.33 percent (Meiteism), 7.67 per cent (Islam) and 2 per cent (Christianity). It can here be concluded that majority of respondents are Hindus.

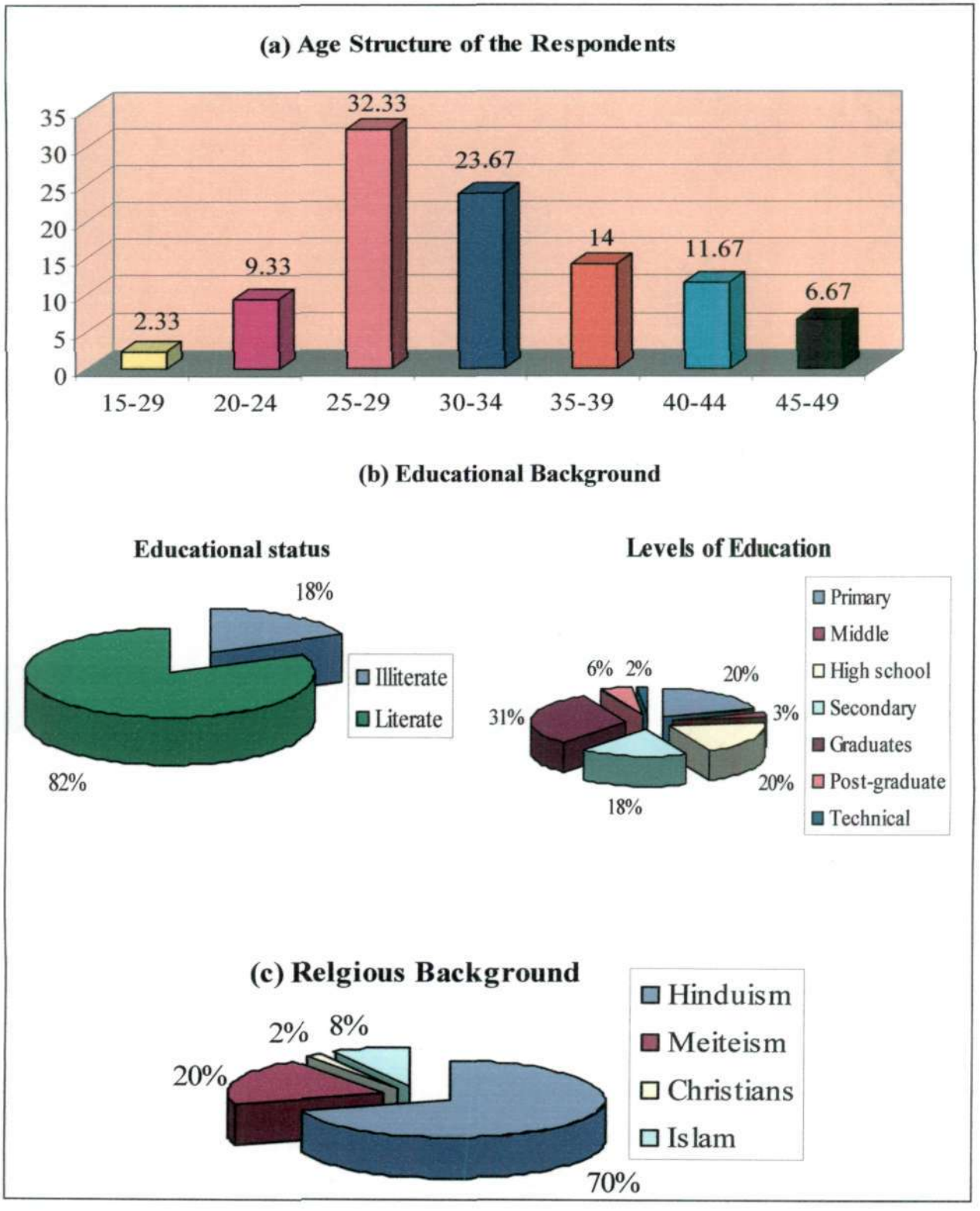
TABLE NO. 4.2

RELIGIOUS BACKGROUND OF RESPONDENTS

Religion	No. of respondents	Percentage
Hinduism	210	70.00
Meiteism	61	20.33
Christianity	6	2.00
Islam	23	7.67
Total	**300**	**100**

Source: Field Survey

Figure 4.1: Social Background of Respondents



Source: Field Survey

Education:

Education is the gateway to women's empowerment. It is one of the best ways of transmitting information to women about their rights more particularly reproductive rights. It is also widely accepted that growth of knowledge affects an individual's life. Literacy among women enables her in improving health, nutrition and education in the family and her capacity to interact with the outside world. Education is thus regarded an important key in empowering women to participate in decision-making in the family as well as the society. In the Programme of Action of the International Conference on Population and Development, held in Cairo in 1994, education is considered as one of the most important means to empower women with the knowledge, skills and self – confidence necessary to participate fully in development processes. Within education, the entry of women into higher education tends to be viewed as landmarks in social development. Most of educated women marry later, want fewer children, are more likely to use effective methods of contraception and have greater means to improve their economic livelihood. Various studies support the inverse relationship between infant mortality and mother's education [1]. According to a study, it is found that mother's education is a more important determinant of child mortality than mother's age, place of residence, or socio-economic status, father's education or occupation, income, or even access to health facilities. [2].

A perusal of table 4.3 and fig. 4.1 (b) shows the distribution of respondents based on education. Majority of respondents 82 per cent are literate and the rest 18 per cent are illiterate. Of the total educated respondents, field surveys reveals that 34.95 per cent of them are educated up to graduate level while 21.95 per cent up to high school level, 19.51per cent up to secondary level, 12.6 per cent up to middle level, 6.09 per cent are post-graduates, nearly 3 per cent up to primary level and 2.03 per cent are into technical line. In conclusion, we can say that majority of respondents are literate and most of them are graduates.

TABLE NO. 4.3

EDUCATIONAL BACKGROUND OF RESPONDENTS

Educational Status	No. of respondents	Percentage
Illiterate	54	18.00
Literate	246	82.00
Total	**300**	**100**
Levels of Education		
Primary	7	2.84
Middle	31	12.6
High school	54	21.95
Secondary	48	19.51
Graduates	86	34.95
Post-graduate	15	6.09
Technical	5	2.03
Total	**246**	**100**

Source: Field Survey

Marital status:

A perusal of table 4.4 and fig. 4.2 (a) shows that all the respondents are married. Of the total respondents, 82 per cent are currently living with husband while 39 per cent are widow, 3 per cent are separated and 2 per cent are divorced.

TABLE NO. 4.4

MARITAL STATUS OF REPONDENTS

Marital status	No. of respondents	Percentage
Currently living with husband	246	82.00
Unmarried	-	-
Divorced	6	2.00
Widowed	39	13.00
Separated	9	3.00
Total	**300**	**100**

Source: Field Survey

It can thus be concluded that maximum number of respondents are currently married and living with husband, while the least number of them are found to be divorced. The number of women who are separated from their husband is also found to be low.

Age at Marriage of Respondents:

In India where marriage occurs at an early age for females, the need for rising the age at marriage is well recognised by both the social scientists and policy makers. In this direction, a number of studies have tried to emphasise the importance of socio-cultural and demographic characteristics that influence age at marriage. Rising the legal minimum age at marriage is seen as one of the few policy implications besides family planning that effect fertility. Since considerable proportions of marriages in India, takes place at the onset of menarche when the young girl is not yet fully grown up; it is detrimental to the health of young girls. Because early marriage leads to early childbearing, where they are already at a greater risk of malnutrition and consequently maternal death and affect the economic resources in the family. Female education is recognised as one of the effective interventions required to raise social consciousness in favour of delaying marriage. Thus, early marriage is both a cause and effect of women's low status, low levels of education and formal employment.

In India, the average age at marriage of the women was 18.0 years (1981-86), which rose to 18.3 years (1986-91), 19.1 years (1991-96) and 19.6 years (1996-01) according to 2001 census.

A perusal of table no. 4.5 and fig. 4.2 (b) reveals that most of the respondents i.e., 39 per cent were married between the age 25-29 years followed by 33.33 per cent (20-24 years), 16 per cent (30-34 years), nearly 7 per cent (35-39 years) and 5 per cent (15-19 years).

The table thus reveals that early marriage is not found in the study area. We can thus conclude that majority of respondents married late when they are 25- 29 years of age while least number of respondents is found to get married early between the age group 15-19 years. Thus, the average age at marriage of respondents is 27 years and so we can conclude that early marriage is not found in the study area.

TABLE NO. 4.5
RESPONDENTS' AGE AT MARRIAGE

Age at marriage	No. of respondents	Percentage
15 – 19	15	5.00
20 – 24	100	33.33
25 – 29	117	39.00
30 – 34	48	16.00
35 – 39	20	6.67
Total	**300**	**100**

Source: Field Survey.

Respondents Residing at Present:

A perusal of table no. 4.6 and fig. 4.3 shows that 81 per cent of respondents are presently residing at husband's family, 4.33 per cent with parents' family, 2 per cent in a rented house and nearly 13 per cent are independent of the above.

In conclusion we can say that majority of respondents are presently staying with husbands' family.

TABLE NO. 4.6
RESPONDENTS PRESENTLY STAYING WITH

Responses	No. of respondents	Percentage
Husband's family	243	81.00
Parent's family	13	4.33
Rented house	6	2.00
Independent of the above	38	12.67
Total	**300**	**100**

Source: Field Survey

Figure 4.2: Marital Status of the Respondents

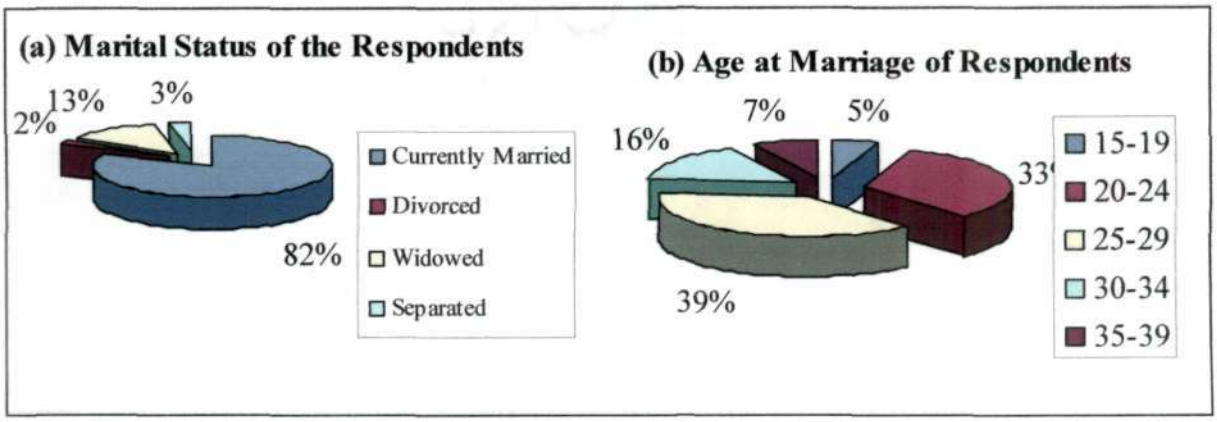


Figure 4.3: Respondents Residing at Present

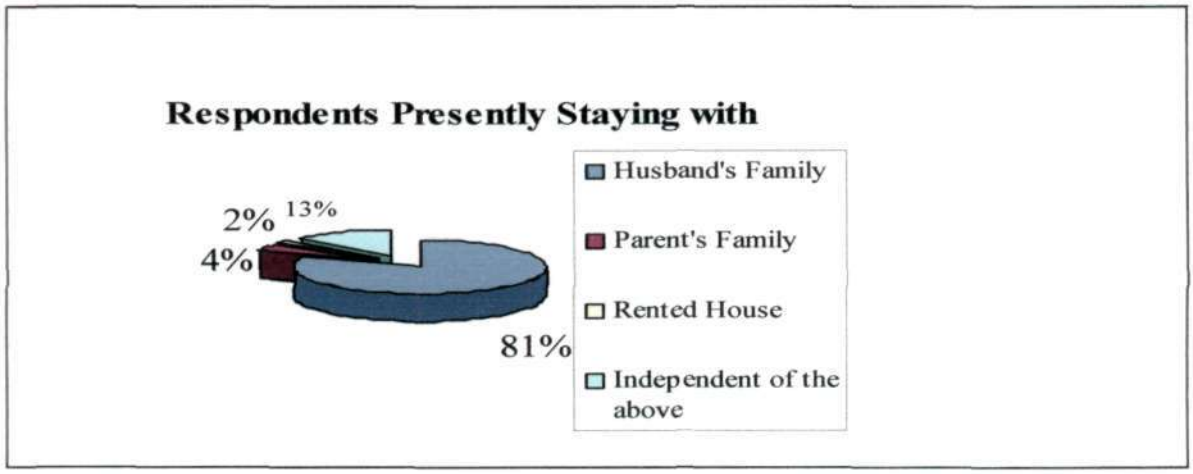
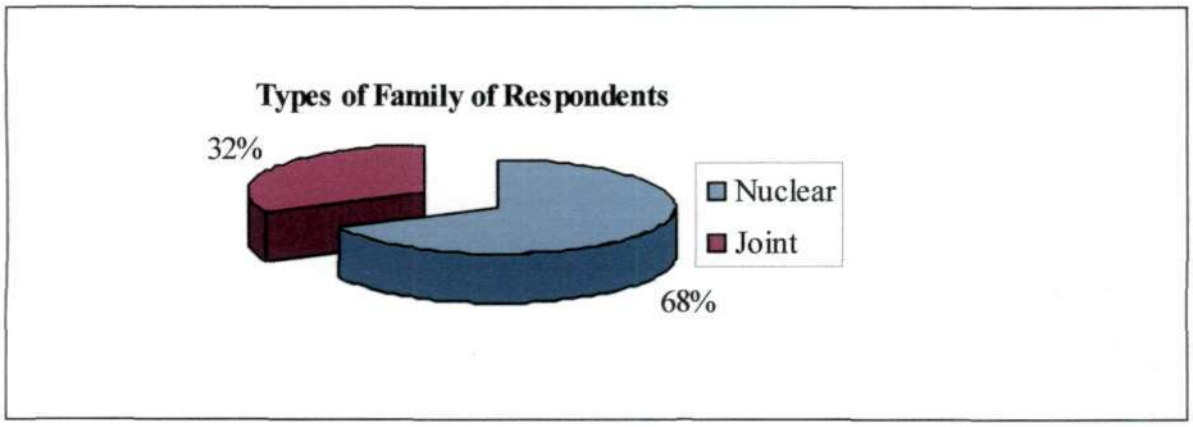


Figure 4.4 Types of Family of the Respondents



Source: Field Survey

Family Types of Respondents:

In India, the traditional joint family system is fast changing into the nuclear type of families. This is true of a small city like Imphal. Perusal of table 4.7 and fig. 4.4 proves the said statement and that 68 per cent of respondents belong to the nuclear type of families, signifying the growing trend in this direction while 32 per cent of the families are joint family type.

It can be concluded that majority of respondents are moving more towards nuclear type of families leaving behind the traditional type of joint family.

TABLE NO. 4.7

TYPES OF FAMILY OF RESPONDENTS

Family types	Responses	Percentage
Nuclear	204	68
Joint	96	32
Total	**300**	**100**

Source: Field Survey

Family Size of Respondents:

Information about the size of family of the respondents is shown in the following table.

TABLE NO. 4.8

FAMILY SIZE

Number of family members	Number of families	Percentage
3 – 4	143	47.67
5 – 6	118	39.33
7 – 8	34	11.33
9 – 10	5	1.67
Total	**300**	**100**

Source: Field Survey

A perusal of table no. 4.8 and fig. 4.5 shows that 47.67 of respondents belong to families of 3-4 family members, followed by 39.33 per cent (5-6 family members), 11.33per cent (7-8 family members) and 1.67 per cent (9-10 family members). Here, it can be concluded that most of the respondents belongs to small type of family, thus showing the trend of moving towards small family type.

Husbands' background

Husbands Age:

As 246 respondents are presently living with husband, the age structure of 246 husbands of respondents are collected and presented in table no. 4.9. A perusal of this table and fig. 4.6 (a) shows that 37.39 per cent of respondents' husbands are in the age group of 36 - 42 years, 31.7 per cent are between 29 - 35 years, followed by 18.69 per cent (43 - 49 years), 8.53 per cent (22-28), 4.47 per cent (50 - 56) and only 0.4 per cent are between 15 - 21 years.

It can be concluded that majority of respondents' husbands are in the age group of 36 - 42 years. Thus, the average age of respondents' husbands is 39 years.

TABLE NO. 4.9

AGE BACKGROUND OF RESPONDENTS' HUSBAND

Husbands' age group	No. of respondents	Percentage
15 – 21	1	0.4
22 – 28	21	8.53
29 – 35	78	31.7
36 – 42	92	37.39
43 – 49	46	18.69
50 – 56	11	4.47
Total	**246**	**100**

Source: Field Survey

Figure 4.5: Size of the Family of Respondents

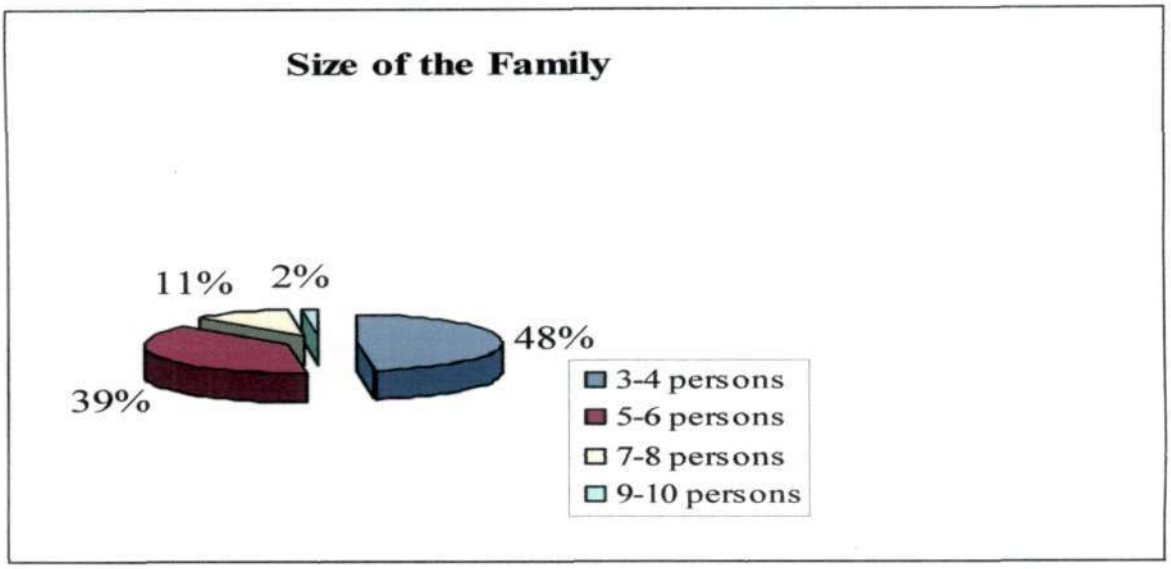
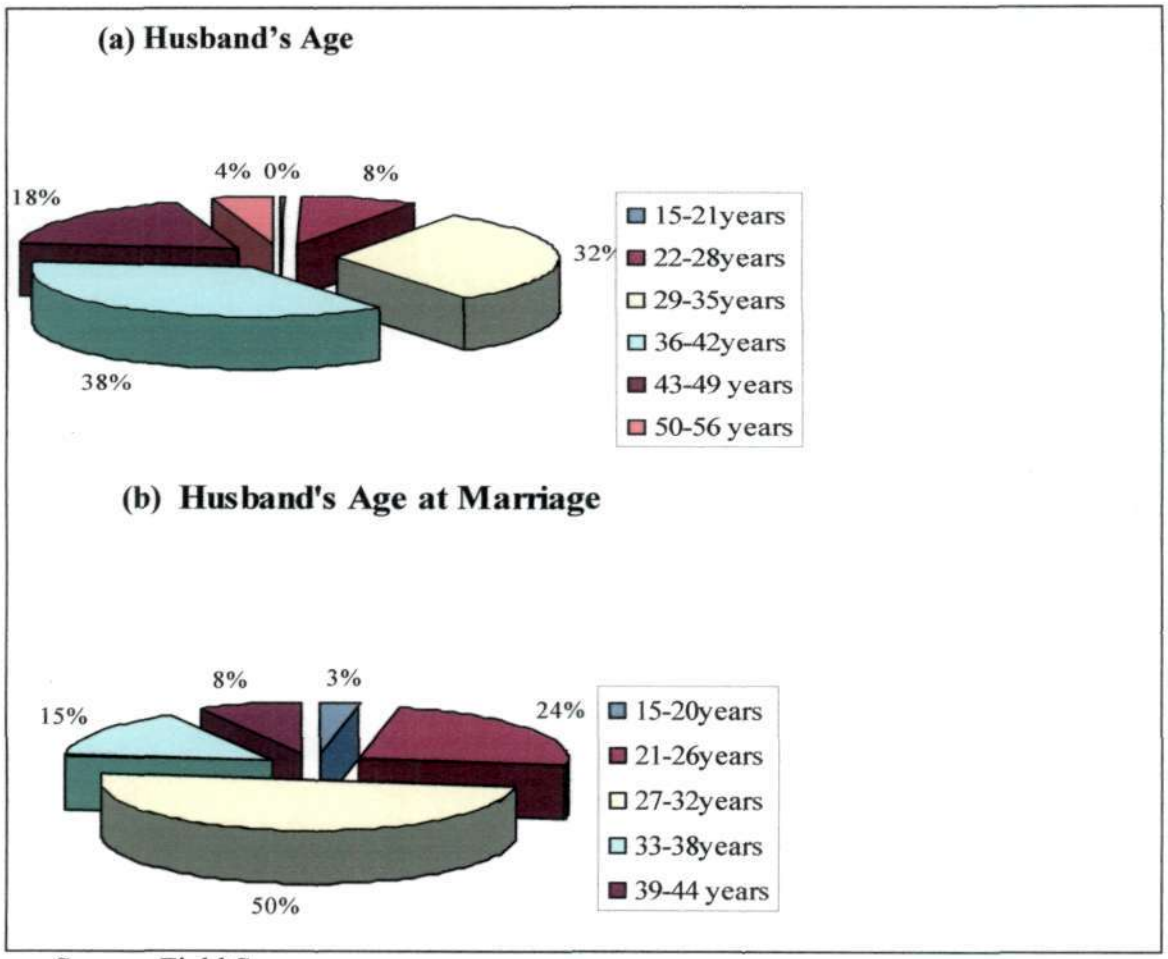


Figure 4.6: Background of Respondents' Husband



Source: Field Survey

Age at Marriage of Respondents' Husband:

The age at marriage of currently married 246 respondents' husbands (presently staying with respondents) are collected and presented in table no. 4.10. A perusal of this table and also of fig. 4.6 (b) shows nearly 49 per cent of respondents' husbands married between the age group (27-32 years) while 24.39 per cent (21-26 years), 15.44 per cent (33-38 years), 8.13 per cent (39-44 years) and 3.25 per cent in the age group of 15-20 years . This reveals that most of respondents' husbands married late as compared with the respondents.

TABLE NO. 4.10

HUSBANDS' AGE AT MARRIAGE

Age group	No. of respondents	Percentage
15 – 20	8	3.25
21 – 26	60	24.39
27 – 32	120	48.79
33 - 38	38	15.44
39 – 44	20	8.13
Total	**246**	**100**

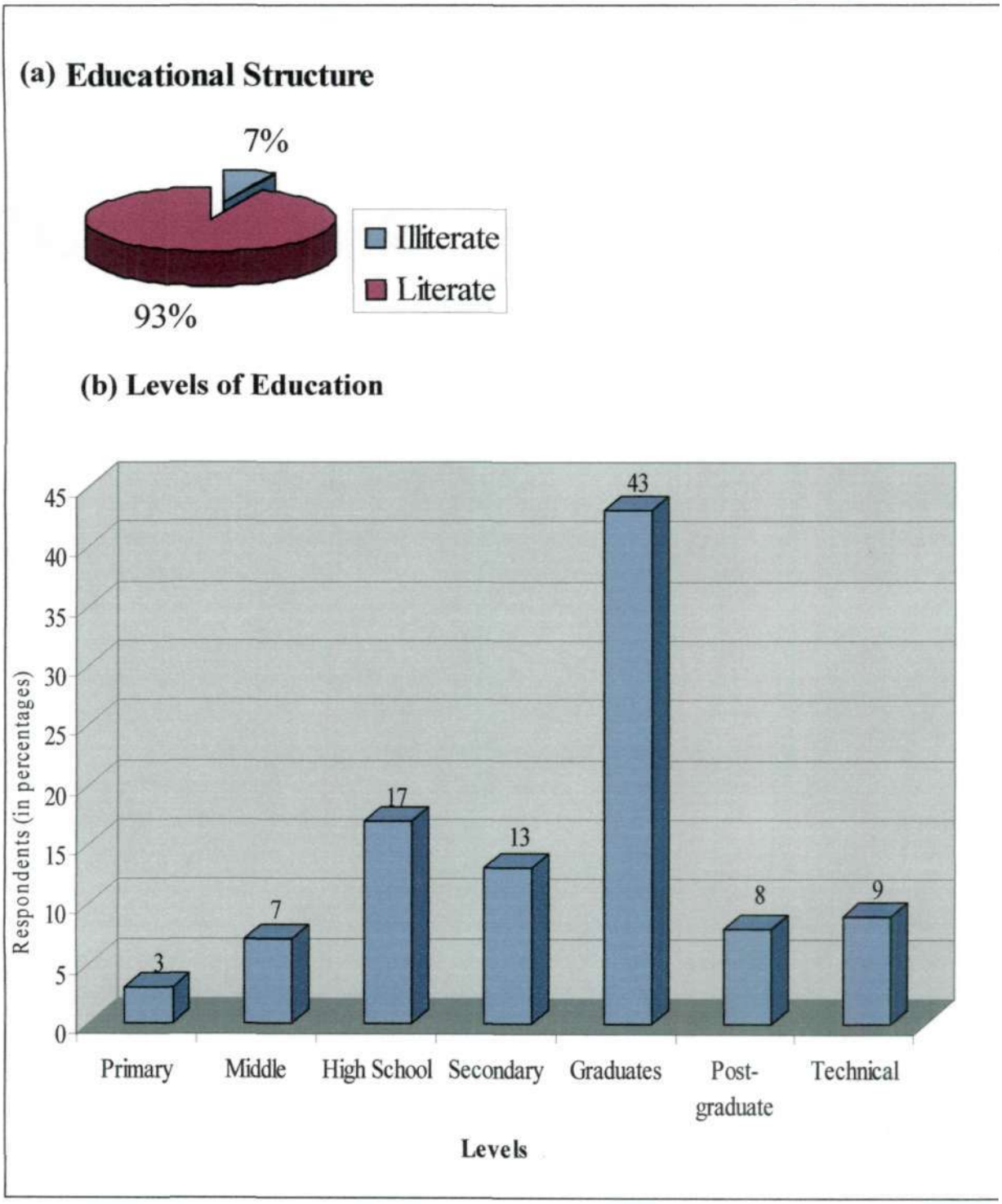
Source: Field Survey

It can thus be concluded that majority of respondents' husbands married between the age group of 27-32 years while the least married between the years 15-20 years. Therefore, the average age at marriage of respondents' husbands is approximately 29 years.

Husbands' Education:

Perusals of table 4.11 and fig. 4.7 (a) shows that a majority of 93.49 per cent of respondents' husband are literate while only 6.50 per cent of them were illiterate. Again, the table and fig. 4.7 (b) shows that 43.47 per cent of them are educated up to the graduation level, while, 17.32 per cent of them are educated up to high school level, and 13.47 per cent up to secondary level, nearly 9 percent of

Figure 4.7: Educational Structure of Respondents' Husband



Source: Field Survey

them are into technical line, 8.26 per cent are post-graduates, 7.39 were educated up to middle level and 2.86 up to primary level. In sum majority of respondents' husbands are literate and most of them are educated up to graduation level.

TABLE NO. 4.11

EDUCATIONAL BACKGROUND OF RESPONDENTS' HUSBAND

Educational structure	**No. of respondents**	**Percentage**
Illiterate	16	6.50
Literate	230	93.49
Total	**246**	**100**
Levels of Education		
Primary	2	2.86
Middle	17	7.39
High school	41	17.32
Secondary	31	13.47
Graduates	100	43.47
Post-graduate	19	8.26
Technical	20	8.69
Total	**230**	**100**

Source: Field Survey

Husbands' Occupation:

A perusal of the following table no. 4.12 and fig. 4.8 (a) shows the distribution of respondents' husbands according to their occupation. It revealed that 42.27 per cent of respondents' husbands were in government service, 30.48 per cent of them were in business, 13.82 per cent were wage earner, and 8.13 per cent were in agriculture and 5.28 per cent of them in others.

We can here sum up that majority of respondents' husbands are in service.

TABLE NO. 4.12
OCCUPATIONAL BACKGROUND OF RESPONDENTS' HUSBAND

Types of occupation	No. of respondents' husband	Percentage
Service	104	42.27
Agriculture	20	8.13
Business	75	30.48
Wage earner	34	13.82
Others*	13	5.28
Total	**246**	**100**

* – artists, carpenters, drivers, shopkeepers, etc.

Source: Field Survey.

Income Structure of Respondents' Husband:

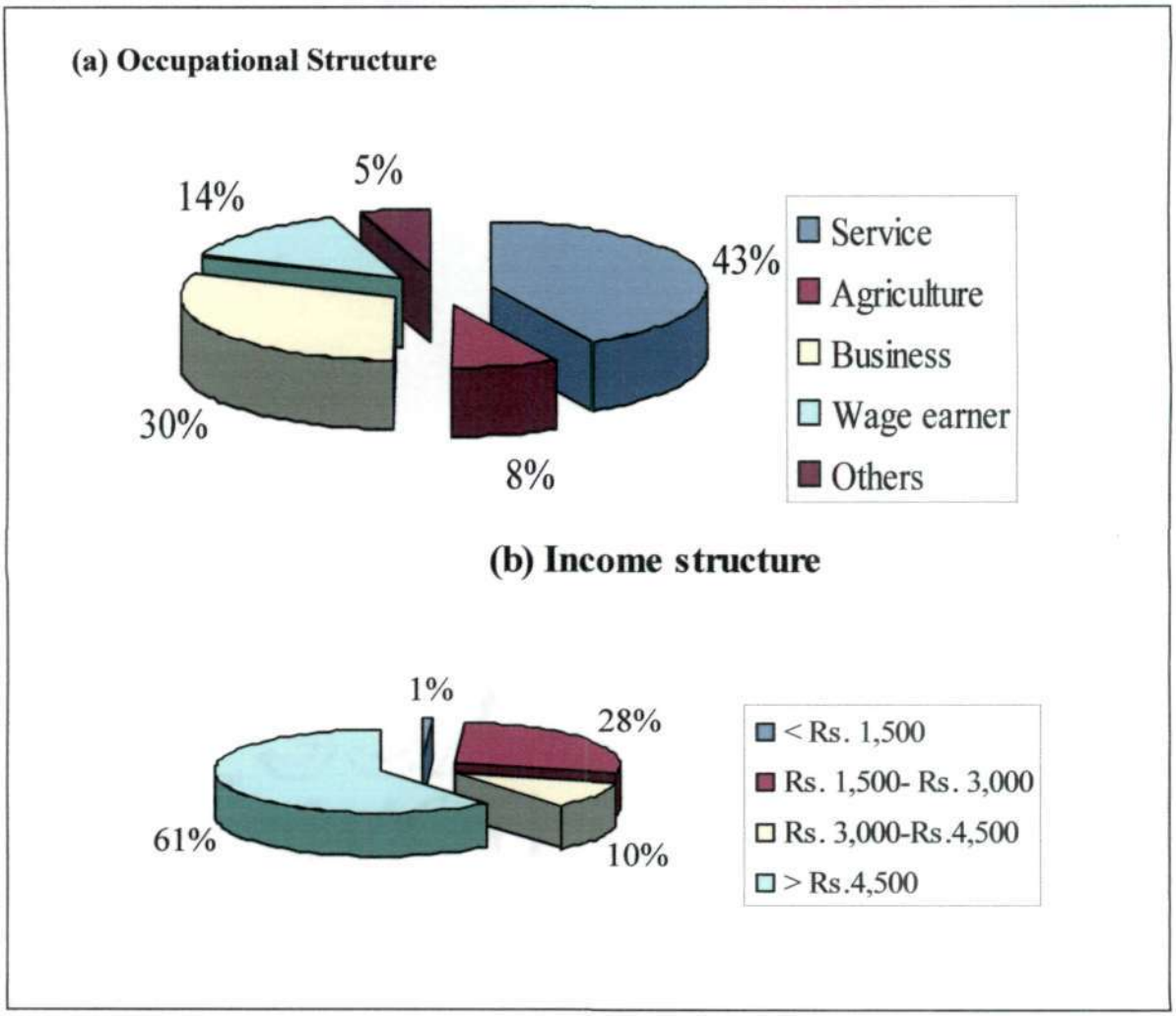
A perusal of table 4.13 and fig. 4.8 (b) shows the distribution of income structure of respondents' husband. About 60.56 per cent of them earns an income of more than Rs.4,500 and 28.04 per cent earns an income of Rs.1,500 to Rs.3,000 while 10.16 per cent earns Rs.3,000 to Rs.4,500 and 1.21 per cent earns an income of less than Rs.1,500. In conclusion we can say that less than half of the respondents' husbands' are in service i. e., salaried class. This shows that most of the respondents belong to middle class families.

TABLE NO. 4.13
INCOME STRUCTURE OF RESPONDENTS' HUSBAND

Income (per month)	No. of respondents husband	Percentage
< 1,500	3	1.21
1500 - 3000	69	28.04
3000 - 4500	25	10.16
> 4500	149	60.56
Total	**246**	**100**

Source: Field Survey.

Figure 4.8: Occupational Structure of Respondents' Husband



Source: Field Survey

Husbands' Qualities according to Respondents:

A perusal of table 4.14 shows that most of the respondents 81.3 per cent thought their husbands' nature as good while 4.06 thought them as bad and the rest 14.64 per cent are indifferent to it.

TABLE NO. 4.14

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THE QUALITIES OF THEIR HUSBAND MENTIONED BY THEM

Husbands' qualities	No. of respondents	Percentage
Good	200	81.3
Bad	10	4.06
Indifferent	36	14.64
Total	**246**	**100**
Relation with their husband		
Understanding	172	69.92
Ill-treated	8	3.25
So-so	66	26.83
Total	**246**	**100**
Husbands' addiction to drinking, gambling, prostitution etc		
Yes	62	25.2
No	184	74.8
Total	**246**	**100**
Husbands' brutality a manly quality		
Yes	52	21.13
No	194	78.87
Total	**246**	**100**
Husband apologised when in sense		
Yes	28	11.38
No	24	9.75
No response	194	78.87
Total	**246**	**100**

Source: Field Survey

According to the respondents, 69.92 per cent of them are having understanding relationship with their husband while 3.25 of them are ill treated by their husband and 26.83 of them are having a relationship not so good and not so bad. Field survey also reveals that 74 per cent of the respondents' husbands are not addicted to drinking, gambling, prostitution etc while 25.2 per cent are addicted to it.

It also reveals that 21.13 per cent of the respondents thought husbands' brutality a manly quality while 78.87 per cent do not agree with them. About 11.38 per cent respondents' husband apologised when in sense while 9.75 per cent do not and 78.87 per cent respondents do not give responses.

Here we can conclude that majority of respondents think their husbands' nature as good, where most of them are having an understanding relationship with husbands. It can also be concluded that maximum number of respondents' husbands are not addicted to drinking, gambling, prostitution etc and some of those addicted do apologises when in sense. Minimum number of respondents also thinks their husbands brutality as a manly quality while majority of them do not think so.

Work Status of Respondent's aside Household Work:

A perusal of the above table 4.15 and fig. 4.9 (I) (a) shows that 76.67 per cent of respondents are working outside aside their household work while 23.33 per cent of them are housewives.

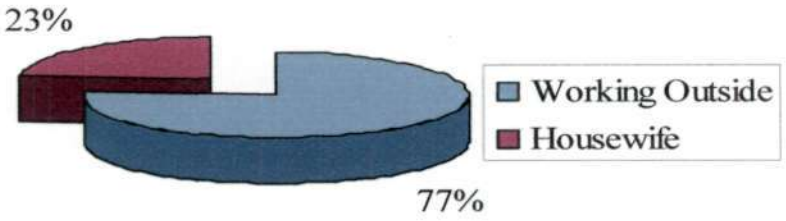
TABLE NO. 4.15
DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THEIR WORKING STATUS

Work status	No. of respondents	Percentage
Working outside	230	76.67
Housewife	70	23.33
Total	**300**	**100**

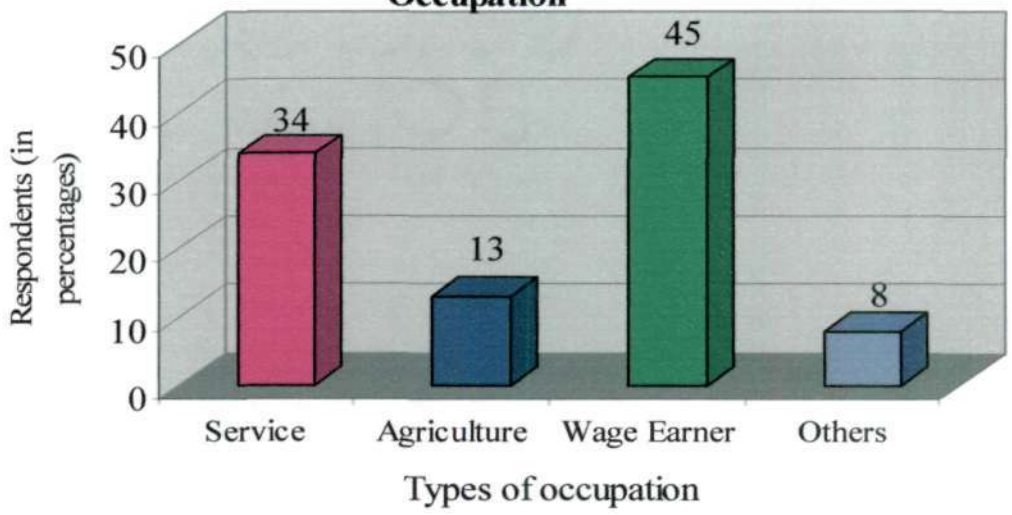
Source: Field Survey

Figure 4.9 (i): Economic Conditions of Respondents According to their Working Status, Occupation and Income

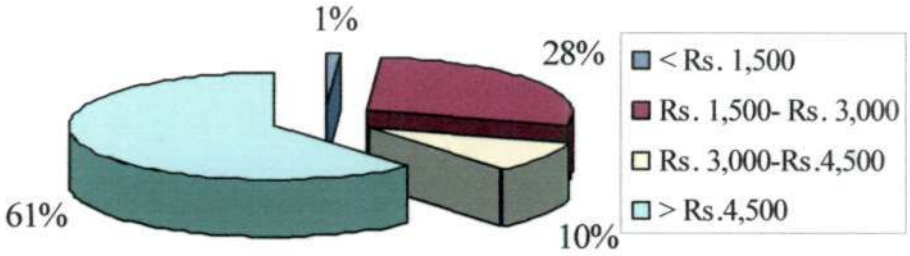
(a) Distribution of Respondents (in percentages) according to their working Status



(b) Distribution of Respondents according to their types of Occupation



(c)Distribution of Respondents (in percentages) according to their income



Source: Field Survey

Occupational Structure of Respondents:

A perusal of table 4.16 shows and fig. 4.9 (I) (b) shows the occupational pattern of the respondents. It is observed that most of the respondents i.e., 40.43 per cent of them are in service, 26.52 per cent of respondents are wage earner, 19.13 per cent in agriculture and the remaining small percentage 13.92 per cent of them are in other activities as artists, shopkeepers etc.

TABLE NO. 4.16

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO TYPES OF OCCUPATION

Types of occupation	No. of respondents	Percentage
Service	93	40.43
Agriculture	44	19.13
Wage earner	61	26.52
Others*	32	13.92
Total	**230**	**100**

* – artists, shopkeepers, etc.

Source: Field Survey

In conclusion we can say that most of the respondents belong to middle class families.

Income Structure of Respondents:

A perusal of table 4.17 and fig. 4.9 (I) (c) shows the income structure of respondents. Most of the respondents i.e., 36.08 per cent of them have a monthly income more than Rs.4,500, 26 per cent have an income of between Rs.1,500-Rs.3,000 and 19.14 per cent have between Rs.3,000-Rs.4,500 and nearly 18 per cent of respondents have less than Rs.1,500 as a monthly income.

In sum, we can conclude that maximum number of respondents is earning a monthly income of more than Rs.4, 500 whereas least number of them is earning less than Rs.1, 500.

TABLE NO. 4.17:

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THEIR INCOME

Income(per month)	No. of respondents	Percentage
< 1500	41	17.82
1500 - 3000	62	26.96
3000 - 4500	44	19.14
> 4500	83	36.08
Total	**230**	**100**

Source: Field Survey

Reasons for Taking up Employment:

A perusal of the following table 4.18 and fig. 4.9 (II) (a) shows that majority of respondents 64.79 have taken up employment on their own choice while 23.04 per cent because of poverty and 12.17 per cent are on husbands' choice.

TABLE NO. 4.18

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THE REASONS FOR TAKING UP EMPLOYMENT:

Responses	No. of respondents	Percentage
Own choice	149	64.79
Poverty	53	23.04
Husbands' choice	28	12.17
Total	**230**	**100**

Source: Field Survey

Here, we can conclude that the reason for taking up employment is the choice of the respondents themselves.

Figure 4.9 (ii): Economic Conditions of Respondents According to the Reasons for Taking up Employment and Contribution to Family Income

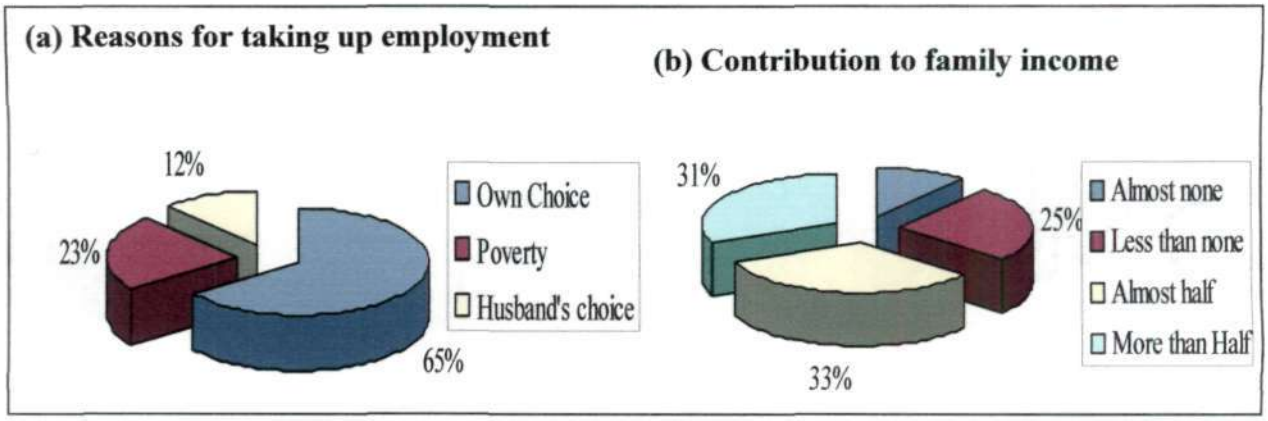
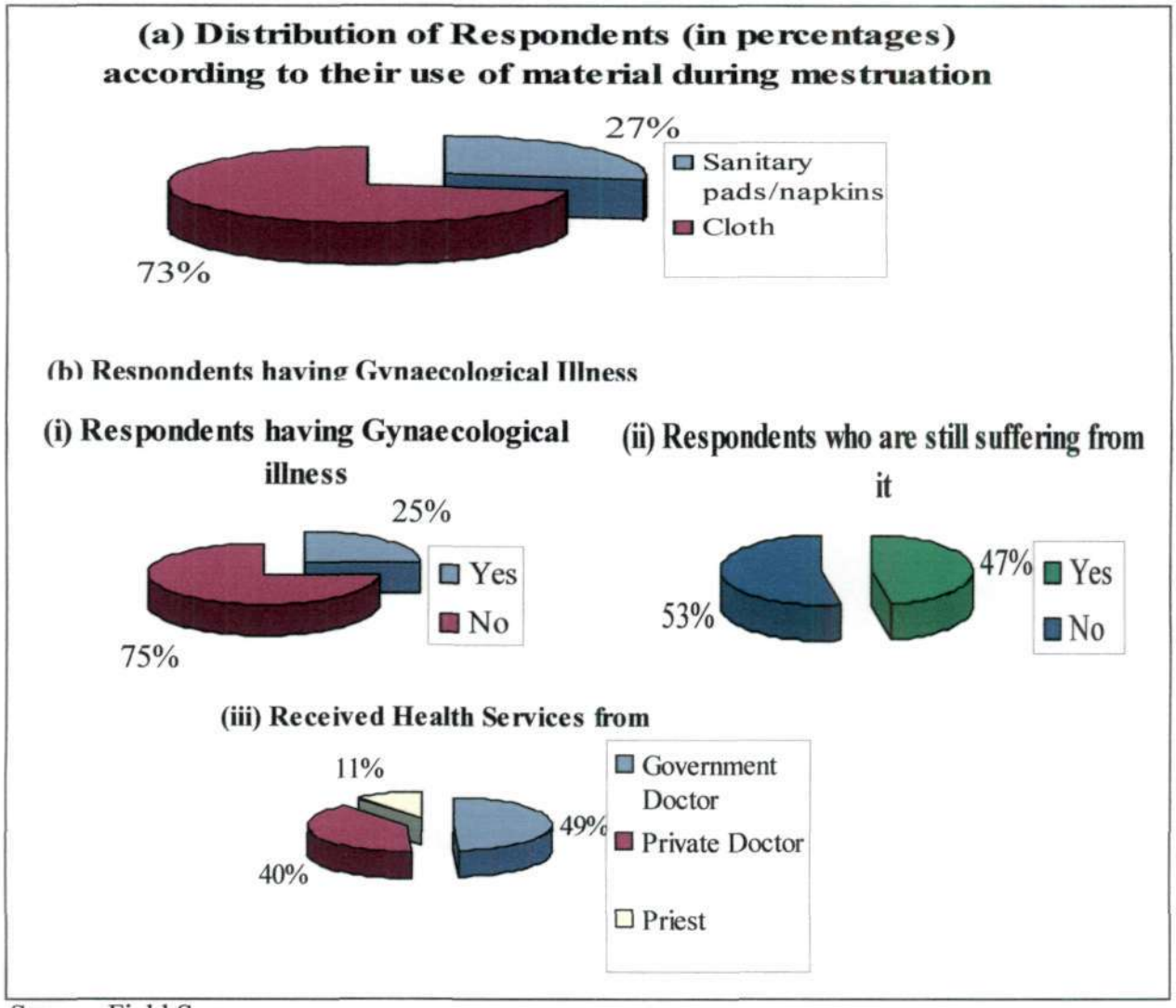


Figure 4.10 (i): Health Profile of Respondents



Source: Field Survey.

Respondents' Contribution to Family Income:

A perusal of the following table 4.19 and fig. 4.9 (II) (b) shows that 33.04 per cent of respondents have contributed almost half of their earning to family income, 31.30 per cent contributed more than half of their earning while 24.78 per cent contributed less than none and 10.88 per cent contributed almost none.

In conclusion we can say that majority of respondents are contributing more than half of their earning to family income.

TABLE NO. 4.19

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THEIR CONTRIBUTION TO FAMILY INCOME:

Responses	No. of respondents	Percentage
Almost none	25	10.88
Less than none	57	24.78
Almost half	76	33.04
More than half	72	31.30
Total	**230**	**100**

Source: Field Survey

Health Profile of Respondents

Use of Material during Menstruation:

In this section the first variable taken up is to find out what type of material the respondents use during menstruation i.e., sanitary pads/napkins or the traditional way of using cloth. The attempt is to explore their awareness level regarding hygienic practices and whether they are following certain myths and taboos relating to menstruation. As already mentioned, maintaining hygienic practices during menstruation is very important and if it is not followed may lead to various severe gynaecological problems.

However a perusal of table 4.20 and fig. 4.10 (1) (a) shows that 73.33 per cent of the respondents are not aware about the hygienic practices they should maintain as they are following the traditional method of using cloth during menstruation. Other unhygienic practice found is the reuse of the same cloth in the next menstruation by washing, drying and keeping it away from the sight of male members in the family. This practice may prove dangerous as far as their health is concern. Further findings indicates them still following myths and restrictions related to menstruation such as not eating certain fruits and vegetables, not touching kitchen utensils and male members, not taking bath during the whole five days of menstruation etc.

While some of the respondents 26.67 per cent are aware of the consequences so they are found using sanitary pads or napkins maintaining the hygienic way. However, even after knowing the ill-effects of the unhygienic practices are helpless because of poverty as most of the respondents do belong to poor families.

TABLE NO. 4.20

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THEIR USE OF MATERIAL DURING MENSTRUATION

Material Used	No. of respondents	Percentage
Sanitary pads/napkins	60	26.67
Cloth	220	73.33
Total	**300**	**100**

Source: Field Survey

Women having gynaecological illness:

A perusal of table 4.21 and fig. 4.10 (I) (b) shows that 25 per cent of respondents are having gynaecological illness while 75 per cent of them do not suffer from it. It is observed that 46.47 per cent respondents are still suffering from it while 53.33 per cent are already cured. Most of the respondents 49.33 per cent

consulted government doctor, 40.00 per cent received treatment from private doctor and 10.67 per cent of the respondents consulted priest to cure their illness.

It can be concluded that some of the respondents are suffering from gynaecogical problems, of which majority of them are cured and the rest are still suffering from it. It can also be summed up here that majority of those who are already cured from the illness mentioned above received treatment from government doctors.

TABLE NO. 4.21

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO WOMEN HAVING GYNAECOLOGICAL ILLNESS

Responses	No. of respondents	Percentage
Yes	75	25.00
No	225	75.00
Total	**300**	**100**
Still suffering from it		
Yes	35	46.67
No	40	53.33
Total	**75**	**100**
Received health services from		
Government doctor	37	49.33
Private doctor	30	40.00
Priest	8	10.67
Others	-	-
Total	**75**	**100**

Source: Field Survey

Another myth that s found to be followed by some of the respondents is the practice of consulting priest in order to cure their illness. It is strange to know that they still believe in consulting priest to solve their health problems. Thus they need to go a long way to realise that there are various other advance services and methods available to deal with their illness.

Antenatal Check-up during Pregnancy:

Antenatal care provides the opportunities for regular checkups during pregnancy to prevent any risks that could affect both the woman and the baby. Throughout human history, pregnancy and childbearing have been a major cause of death and disability among women. This risks that women carry can be prevented if timely health care interventions is given with the necessary skills, equipment and medicines so as to prevent and manage complications. Maternal mortality i.e., the death of a woman during pregnancy, delivery and postpartum period, is said to be a key indicator of women's health and status.

TABLE NO. 4.22

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THEIR ANTENATAL CHECK-UP DURING PREGNANCY

Responses	No. of respondents	Percentage
Yes	273	91.00
No	27	9.00
Total	**300**	**100**

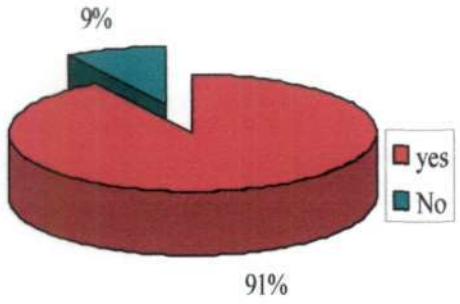
Source: Field Survey

A perusal of table 4.22 and fig. 4.10 (II) (c) shows that 91 per cent of respondents go for antenatal check-up during pregnancy while the remaining 9 per cent do not go for it.

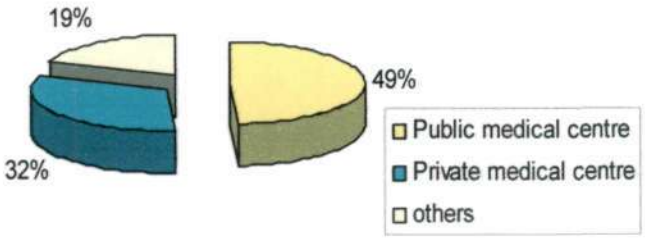
We can here conclude that majority of respondents go for antenatal check-up during pregnancy showing that majority of them are health conscious and fully utilise the available health services. However, some of the respondents do not feel the need to go for such kind of checkups either because of ignorance, carelessness, lack of time, poverty etc.

Figure 4.10 (ii): Health Profile of Respondents

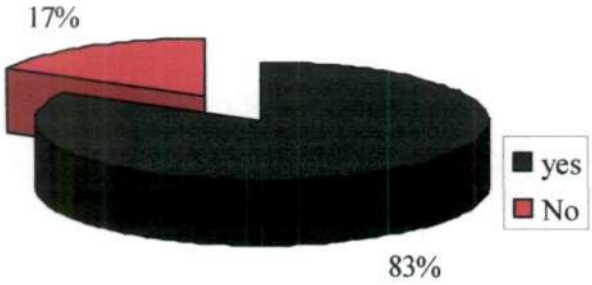
(c) Antenatal check-up during pregnancy



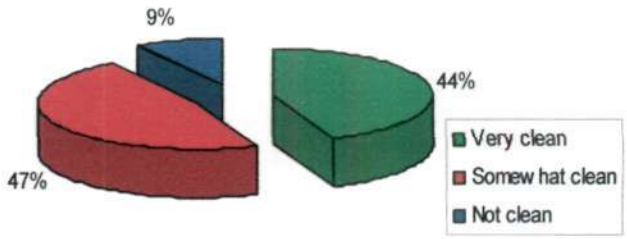
(d) Types of Health centre visited



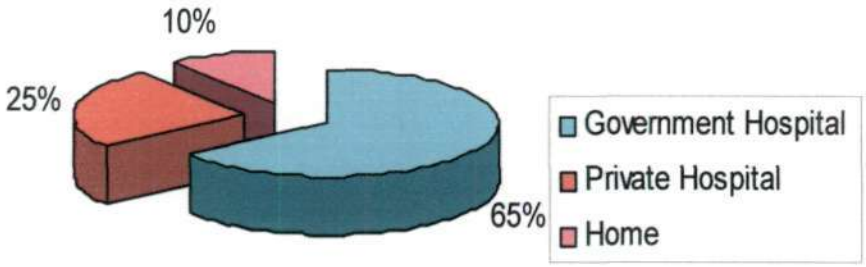
(e) Received health services respondents want



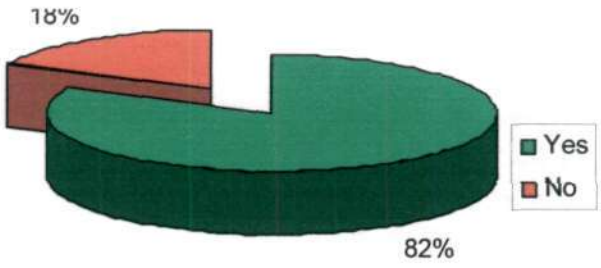
(f) Condition of health facility visited



(g) Place of giving birth to child



(h) Postnatal check-up



Source: Field Survey.

Types of Health Facility Visited for Routine Check-up during Pregnancy:

A perusal of the above table 4.23 and fig. 4.10 (II) (d) shows the health facility visited by respondents for routine check-up during pregnancy. It can be seen from this table that 49.33 per cent of respondents visited public medical centre, while, 31 per cent visited private medical centre and 19 per cent visited others.

TABLE NO. 4.23

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THE HEALTH FACILITY VISITED FOR ROUTINE CHECK-UP DURING PREGNANCY

Health facility visited	No. of respondents	Percentage
Public medical centre	148	49.33
Private medical centre	95	31.67
Others*	57	19.00
Total	**300**	**100**

* - Priest etc.

Source: Field Survey

In sum, we can say that majority of respondents visited public medical centre during their antenatal check-up during pregnancy. It is also found that some of the Manipuri women went to visit priest for their antenatal care. Thus one can see that modern health care services and traditional way/method is going side by side in Manipuri society.

Received the Services Respondents Want during their Visit to Health *Centres:*

The attempt here is to ensure that health services are appropriate, acceptable, of high quality and responsive to the needs of women.

TABLE NO. 4.24

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THE SATISFACTION OF THE SERVICES THEY RECEIVED DURING THEIR VISIT TO HEALTH CENTRES

Responses	No. of respondents	Percentage
Yes	201	82.72
No	42	17.28
Total	**243**	**100**

Source: Field Survey

Perusals of table 4.24 and fig. 4.10 (II) (e) reveals that 82.72 per cent of respondents are satisfied with the services they received during their visit to the health centres. Whereas 17.28 per cent of them are not satisfied and do complain that they do not receive the services well as to their expectation. This factor thus may restrain women from visiting such places for their checkups.

Condition of Health Facility Visited:

Attempt that is made here is explore whether unhygienic condition of the available health facilities is responsible for keeping women away from going for the necessary checkups.

TABLE NO. 4.25

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THEIR OPINION OF THE CONDITION OF HEALTH FACILITY VISITED

Responses	No. of respondents	Percentage
Very clean	108	44.44
Somewhat clean	114	46.92
Not clean	21	8.64
Total	**243**	**100**

Source: Field Survey

A perusal of table 4.25 shows and fig. 4.10 (2) (f) shows that 46.92 per cent of respondents feel the health facility visited as somewhat clean, 44.44 per cent feel it to be very clean and 8.64 per cent think it to be unclean.

We can conclude that most of the respondents regarded the hygienic condition of the health centre they visited as not much to their expectation thus, suggesting it a contributing factor for stopping women from visiting such places.

Place of Giving Birth to Child:

Complications during pregnancy and childbirth are the leading causes of death, disease and disability among women of reproductive age in developing countries. Place of birth and types of assistance during birth have an impact on maternal health and mortality. Births that take place in non-hygienic conditions of births that are not attended by trained medical personal are more likely to have negative outcomes for both the mother and the child. WHO in a report in 2000, reported that every day at least 1,600 women die from complications of pregnancy and childbirth, amounting to at least about 585,000 women dying each year.

A perusal of table 4.26 and fig. 4.10 (H) (g) shows that most of the respondents 64.67 per cent give birth at government hospital, 25 per cent at private hospital and 10.33 per cent at home.

TABLE NO. 4.26

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THE PLACE OF BIRTH OF CHILD

Responses	No. of respondents	Percentage
Government Hospital	194	64.67
Private Hospital	75	25.00
Home	31	10.33
Total	**300**	**100**

Source: Field Survey

In sum, it can be concluded that majority of respondents are in favour of giving birth to a child at hospital which is a good sign because delivery care

ensures that obstetric emergencies are effectively managed that can safe many a women's life. We can also see some of the women who because of poverty, lack of knowledge, physical inaccessibility or carelessness do not go to a hospital but give birth to their child at home only.

Post-natal Check-up:

Postnatal care is important for detecting and treating infections and other risky conditions that may arise because of childbirth such as depression and also other advice that women may get on family planning.

Table 4.27 and fig. 4.10 (II) (h) shows that majority of the respondents 82 per cent of respondents go for post-natal check-up. This indicates that women in Manipur are aware about the various risks – the woman and child may face after childbirth. At the same time we cannot say that all the women in Manipur are taking care of their health because 18 per cent of them do not go for postnatal care because of carelessness, lack of time, poverty, no one to give company, distance far away etc.

TABLE NO. 4.27

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THEIR POST-NATAL CHECK-UP

Responses	No. of respondents	Percentage
Yes	246	82.00
No	54	18.00
Total	**300**	**100**

Source: Field Survey

Practice of Family Planning

Contraceptive Prevalence:

The use of effective contraceptive methods would enable women to achieve the desired number of children and help in reducing the number of unwanted pregnancies[3]. When women can time and space their pregnancies, families are

smaller and more prosperous and children are healthier and better educated. There is a dramatic shift in the initiation of contraceptive use all over the country and the demand for its effective use is expected to increase further in the coming decades, with the increase in the reproductive age groups. It was reported that due to the absence of an ideal method one out of every five women, abort an unwanted and unplanned pregnancy [4].

The contraceptive prevalence rates vary widely between regions, socio-economic groups, etc [5]. Various factors such as income, education, number of living children, and age are known to be important determinants of knowledge and use of contraception. Women under age 30 years or who have two children or one son or are illiterate practice any form of contraception whereas the rates rise among women who are above 39 years with four or more children or two or more living sons, or matriculates with ten years of schooling [6].

Knowledge Regarding Contraception:

TABLE NO. 4.28

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THEIR KNOWLEDGE ON AVAILABLE CONTRACEPTIVES

Knowledge on contraception	No. of respondents	Percentage
Yes	216	87.81
No	30	12.19
Total	**246**	**100**
Contraceptive ways heard about		
Copper-T	10	24.79
Sterilisation	98	43.49
Condom	81	32.92
Pills	41	16.66
Withdrawal	3	1.21
Periodical	13	2.84
Abstinence	-	-
Total	**246**	**100**

Source: Field Survey.

A perusal of table 4.28 and fig. 4.11(I) (a) and (b), shows that most of the respondents about 87.81 per cent are having knowledge on contraception, while only 12.19 per cent are ignorant of it. 43.49 per cent heard about sterilisation, followed by 32.92 per cent (condom), 24.79 per cent (Copper-T), 16.66 per cent (pills), 2.84 per cent (periodical), and 1.21 per cent (withdrawal).

Thus, majority of respondents are aware of the various available contraceptives and among the respondents, sterilisation is the method which most of them have heard about while least number of them heard about withdrawal.

Contraceptive Ways Ever Used:

The distribution of respondents by their ever used of contraceptive methods is given in table 4.29. A perusal of this table and fig. 4.11(I) (c) shows that 47.97 per cent of respondents never used contraception while a little more than 50 per cent of the respondents are current contraceptive users. Though earlier revelations suggest maximum heard about sterilisation method, the present table shows that among the current users, copper-T heads the list of the available contraceptive method they ever use while least number of them uses periodical method.

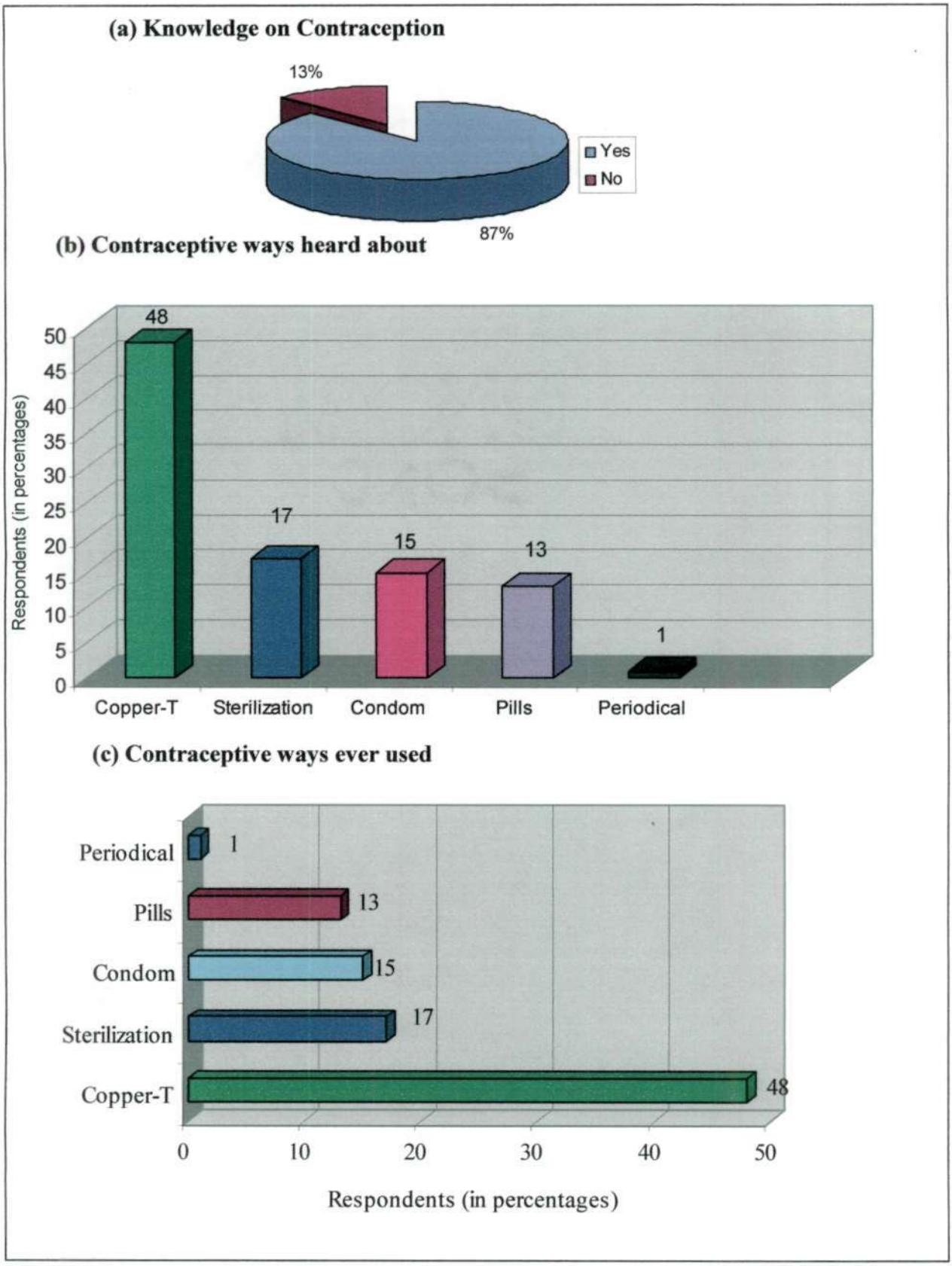
TABLE NO. 4.29

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THEIR USE OF VARIOUS AVAILABLE CONTRACEPTIVES

Ever used Contraceptives	No. of Respondents	Percentage to Contraceptors	Percentage
Nil	118	-	47.97
Copper-T	42	32.82	17.07
Condom	36	28.12	14.64
Pills	32	25.00	13.02
Sterilisation	15	11.72	6.09
Periodical	3	2.34	1.21
Abstinence	-	-	
Total	**246**	**100**	**100**

Source: Field Survey

Figure 4.11(i): Contraceptive Prevalence among Respondents



Respondents' Intention to Use Contraception in Future:

A perusal of the table and fig. 4.11(II) (a) shows that among the current users of various contraception, it is found that 39.85 per cent of respondents are intending to use contraceptive methods in future while majority of them 60.15 are not in favour to continue its use in future. This may be due to the side effects they faced during the usage.

TABLE NO. 4.30

PERCENTAGE DISTRIBUTION OF RESPONDENTS ON THEIR INTENTION TO USE CONTRACEPTION IN FUTURE

Intend to use in future	Number of respondents	Percentage
Yes	51	39.85
No	77	60.15
Total	**128**	**100**

Source: Field Survey

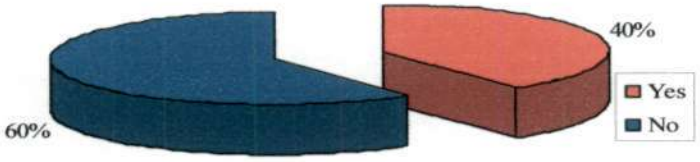
Opinion on Using Contraceptive Ways according to Respondents:

The following table 4.31and fig. 4.11(II) (b) shows the opinion of respondents and of their husbands' (according to the respondents), on the use of contraception. We can see that 60.57 per cent respondents approves of using contraceptive methods while only 42.27 per cent of respondents' husband approves its usage. Again according to the respondents, they did not know whether their husband (34.14 per cent) approved or disapproved the use of contraceptive methods. This clearly shows the wide communication gap regarding their sexual life.

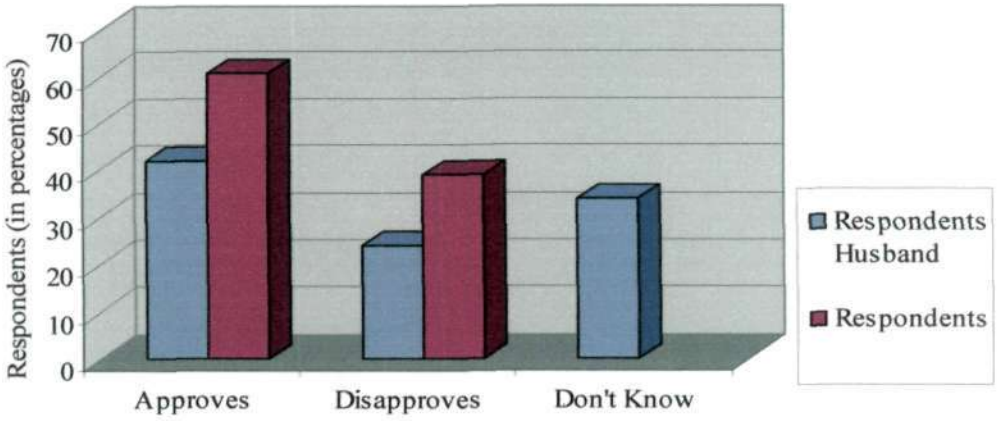
We can however conclude that more number of respondents approves of using various available contraceptive methods as compared with respondents' husband.

Figure 4.11 (ii): Contraceptive Prevalence among Respondents

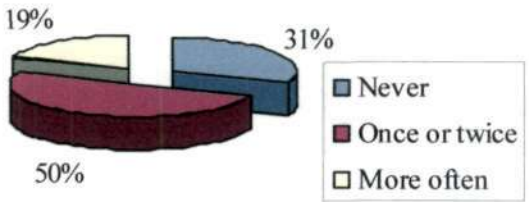
(a) Respondents intention to use contraception in future



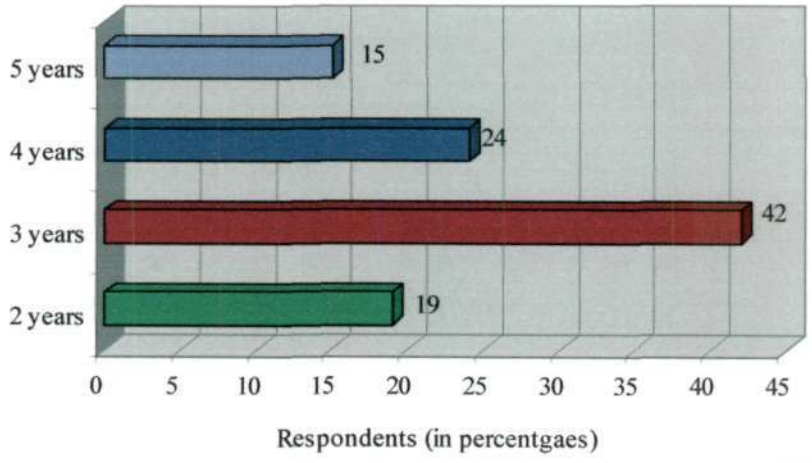
(b) Opinion on using contraception according to respondents



(c) Talk about family planning with husband



(d) Respondents' opinion of birth intervals in years



Source: Field Survey

TABLE NO. 4.31

OPINION OF RESPONDENTS AND THEIR HUSBANDS (IN PERCENTAGES) ON USING CONTRACEPTIVE WAYS ACCORDING TO THE RESPONDENTS

Opinion	Respondents'	Percentage to the total	Respondents' Husband	Percentage
Approves	149	60.57	104	42.27
Disapproves	97	39.43	58	23.59
Don't know	-	-	84	34.14
Total	**246**	**100**	**246**	**100**

Source: Field Survey

Talked About Family Planning with Husband:

A perusal of the above table 4.32 and fig. 4.11(II) (c) shows how often the respondents talks about family planning with their husband. It is observed that 30.9 per cent of respondents never talks about family planning with their husband, while 50.00 per cent of them talks once or twice and 19 per cent of them talks more often.

TABLE NO. 4.32

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ON TALKING ABOUT FAMILY PLANNING WITH HUSBAND

Responses	No. of respondents	Percentage
Never	76	30.9
Once or twice	123	50.00
More often	47	19.1
Total	**246**	**100**

Source: Field Survey

In conclusion, we can say that half of the talks about family planning with their husband only once or twice while least number of them talks more often about it. This indicates the absence of communication between the respondents and their husbands and it is obvious that women have no say in decision relating to their sex life.

Respondents' Opinion of Birth Intervals in Years:

TABLE NO. 4.33

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THEIR OPINION OF BIRTH INTERVALS IN YEARS

Opinion in years	No. of respondents	Percentage
2	57	19.00
3	126	42.00
4	73	24.33
5	44	14.67
Total	**300**	**100**

Source: Field Survey

A perusal of table 4.33 and fig. 4.11(II) (d) shows that 42 per cent of respondents are in favour of 3 years birth intervals while 24.33 per cent (4 years), 19 per cent (2 years), and 14 per cent are of the opinion of 5 years birth intervals.

We can conclude that majority of respondents are in favour of 3 years birth interval and least number of them are in favour of 5 years birth interval. However, though most women are in favour of more gap in years in terms of birth intervals, they cannot do anything as the decision on number of children lies not in their hands.

Decision-making Profile of Respondents:

Selection of Life-partner:

The following table 4.34 and fig. 4.12(I) (a) shows the decision-making of respondents in choosing life-partner. It can be seen that majority of the respondents (77 per cent) have chosen their life-partner on their own while it is the family members for 23 per cent of respondents.

In sum we can say that majority of respondents have the decision-making power of choosing their life-partner themselves. It is thus an exception to see in the Indian society that in Manipuri society, majority are having the power to

choose their own life partner. In this case, one can easily say that women are empowered but there are various reasons that can be mentioned. One reason is the tradition of choosing life partner has been going on from one generation to the other and even if parents are against it, the boy and the girl used to elope and get married. At that condition the parents can do nothing but to agree to their children's wishes. So marriage by elopement is very much practice in Manipur.

TABLE NO. 4.34

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ON THE DECISION OF CHOOSING LIFE-PARTNER

Decision	No. of respondents	Percentage
On their own	231	77.00
Family members	69	23.00
Total	**300**	**100**

Source: Field Survey

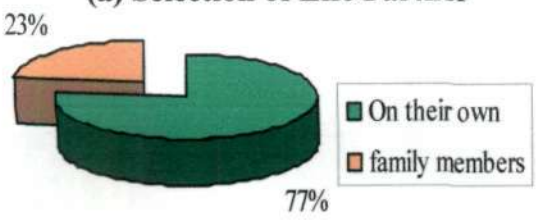
Another thing is that if the tradition of marriage by elopement is not prevalent in Manipuri society, the case would have been different. Women may not have that much power to choose their husband of their liking. But at this point of time, we can say that most of the women are empowered in terms of choosing their life partner as marriage by elopement is in their favour.

Decision on consulting doctor:

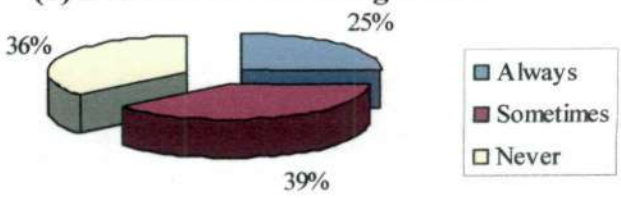
Thus, it is clear in table 4.35 and fig. 4.12(I) (b) that only few of the respondents have the power to always decide whether to bring their children to a doctor or not without consent in case when their children got ill. Such women are found to be economically independent and are main bread earners in the family.

Figure 4.12 (i): Decision making Profile of Respondents

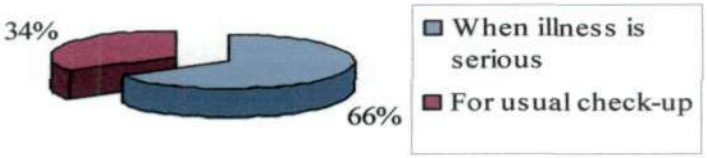
(a) Selection of Life Partner



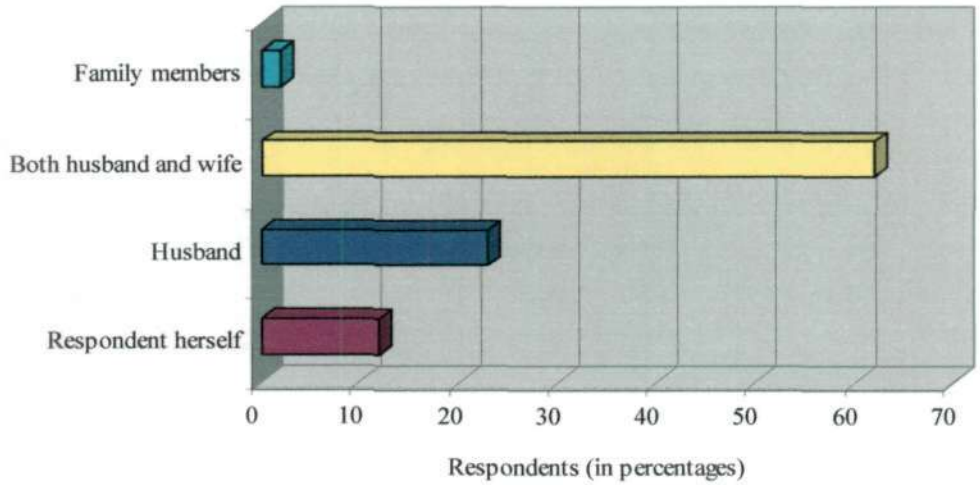
(b) Decision on consulting Doctor



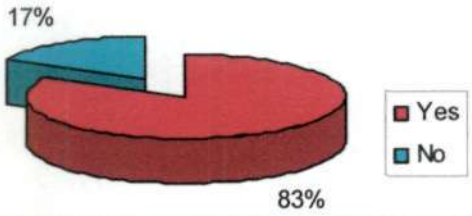
(c) Reason for consulting doctor



(d) Decision on the number of children respondents would have in future



(e) Respondents Freedom to spend own income



(f) Respondents Dependency on family for economic needs

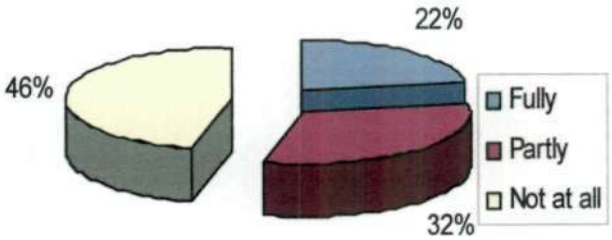


TABLE NO. 4.35
DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ON TAKING THEIR CHILDREN TO A DOCTOR WITHOUT CONSENT OF HEAD OF FAMILY

Responses	No. of respondents	Percentage
Always	74	24.66
Sometimes	117	39.00
Never	109	36.34
Total	**300**	**100**

Source: Field Survey

It is also found that there is no distinction between male and female child, in terms of providing education, food and other care; though preference for son can be seen (mainly first birth).

So the respondents do not see whether the child who got ill is a boy or a girl but do carry them to consult a doctor. Again, some women a little more than one third have the power of decision making in consulting doctor, only sometimes but not always. A good number of them, 36 per cent are still in a condition where they can never take their children to a doctor without consent from the family head. The result shows that majority of the respondents are not able to make decision of their own without consent of family members, when only a few of them always do so. Thus, it can be here concluded that majority of the women in Manipur are not empowered.

A perusal of table 4.36 shows that 53 per cent of the respondents do not believe that diseases can be cured by offering to Gods and Goddesses while at the present age, still some of the respondents 29.34 per cent believes to some extent and 17.66 believes in it totally.

The table thus indicates that when majority of the respondents do not believe in diseases cured by offering to Gods and Goddesses, there are number of women who are following this belief at the same time. Here we can say that tradition and modernity is going side by side.

Believes in Illness Cured by Offering to Gods and Goddesses:

TABLE NO. 4.36

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THEIR BELIEVE ON CURING ILLNESS BY OFFERING TO GODS AND GODDESSES

Responses	No. of respondents	Percentage
Believe	88	17.66
Don't	159	53
Only to some extent	53	29.34
Total	**300**	**100**

Source: Field Survey

Reasons for Consulting Doctor:

To look into how the respondents care for their health, an attempt is made to examine whether they go for normal check up or not. A perusal of table 4.37 and fig. 4.12 (I) (c) shows that 65.67 per cent of respondents do not care about their health but consulted a doctor only when they fall ill and their illness is serious.

TABLE NO. 4.37

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ON THE REASON FOR CONSULTING DOCTOR

Responses	No. of respondents	Percentage
When illness is serious	197	65.67
For usual check-up	103	34.33
Total	**300**	**100**

Source: Field Survey

Further, the respondents reveal that they never think of visiting a doctor only for usual checkup but they do self medication if their illness is not serious. Some do not have time, while others have shortage of money. So in such situation

they hardly think of going for a usual checkup. However, 34.33 per cent of them went only for usual check-up as also shown in the table. This clearly indicates that some of the women respondents do go for usual checkup but majority do not do so.

Decision on the number of Children Respondents would have (in Future):

As mentioned earlier, majority of the respondents do not discuss with their husband on areas relating to family planning, sexual life, contraception etc. In such situation where talking about sex is not encourage, we cannot think that the respondents will be talking with their husband about the number of children they would like to have in future. As shown in the table, though 62 per cent of the respondents reveal having made the decision along with their husband, it is hard to believe because only 11 per cent of the respondents are able to make decisions on their own regarding the number of children they wish to have. So at the end it is only the husband's decision that matters, even if they say it is a joint one.

TABLE NO. 4.38

PERCENTAGE DISTRIBUTION ON THE DECISION OF THE NUMBER OF CHILDREN RESPONDENTS WOULD HAVE (IN FUTURE)

Decision	No. of responses	Percentage
Respondent herself	29	11.78
Husband	57	23.17
Both husband and wife	154	62.6
Family members	6	2.43
Total	**246**	**100**

Source: Field Survey

Responsibility of Spending Family Income:

As far as spending family income is concern, 37 per cent of the husband and wife are found to be jointly responsible for spending family income. A look into the individual decision making in spending family income, it s reveal that while 25 per cent of the respondents' husbands take decision on their own, it is 26 per cent of the respondents who make the decision. So the number is more or less the same. The reason is because majority of the respondents are earning and they do have a say in spending the income they earn.

TABLE NO. 4.39

PERCENTAGE DISTRIBUTION ON THE RESPONSIBILITY OF SPENDING FAMILY INCOME

Responsibility	Responses	Percentage
Father-in-law	23	7.67
Mother-in-law	11	3.67
Husband	76	25.33
Both husband and wife	111	37.00
Respondent	79	26.33
Total	**300**	**100**

Source: Field Survey

Respondents' freedom to spend one's income:

TABLE NO. 4.40

PERCENTAGE DISTRIBUTION OF RESPONDENTS ON THEIR FREEDOM TO SPEND ONE'S OWN INCOME

Freedom to spend one's own income?	No. of respondents	Percentage
Yes	192	83.47
No	38	16.53
Total	**230**	**100**

Source: Field Survey

Table 4.40 and fig. 4.12(I) (e) shows that out of the working 230 respondents, majority 83.47 per cent of them are able to spend their own income indicating that they are economically independent and can make decision of their on. However, there are also women, who are earning but they cannot spend the money as per they wish. The decision is left either in the hands of the husband or family head. So, we can say that there are many women who despite earning for the family cannot make their decision of spending it. This clearly shows their subordinate status who cannot voice their wishes but enjoying a dependent life throughout their life.

Respondents Depending on the Family for Economic Needs:

A perusal of table 4.41 and fig. 4.12(I) (f) shows the dependency of respondents for economic needs on the family.

In sum, we can say that one third of the respondents are fully dependent on their families for their economic needs. Most of them are those who are not earning. Further, a little less than half of the respondents are partly dependent while only 22 per cent of them are not dependent at all for their economic needs. This is despite the fact that majority of them are earning but still are dependent on their families in one way or the other. This clearly reveals that women though earning and contributing in the family needs are dependent either fully or partly, so we can say that most of the respondents are not empowered.

TABLE NO. 4.41

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THE DEPENDENCY ON FAMILY FOR ECONOMIC NEEDS

Levels of dependency	Respondents	Percentage
Fully	95	31.66
Partly	139	46.34
Not at all	66	22.00
Total	**300**	**100**

Source: Field Survey

Savings on Respondents' Name:

A perusal of the above table 4.42 and fig. 4.12(II) (a) shows that most of the respondents 69.33 per cent of them have separate savings on their name while 30.67 per cent do not have any such savings.

TABLE NO. 4.42

PERCENTAGE DISTRIBUTION OF RESPONDENTS ON THEIR SAVINGS IF ANY

Savings if any	No. of respondents	Percentage
Yes	208	69.33
No	92	30.67
Total	**300**	**100**

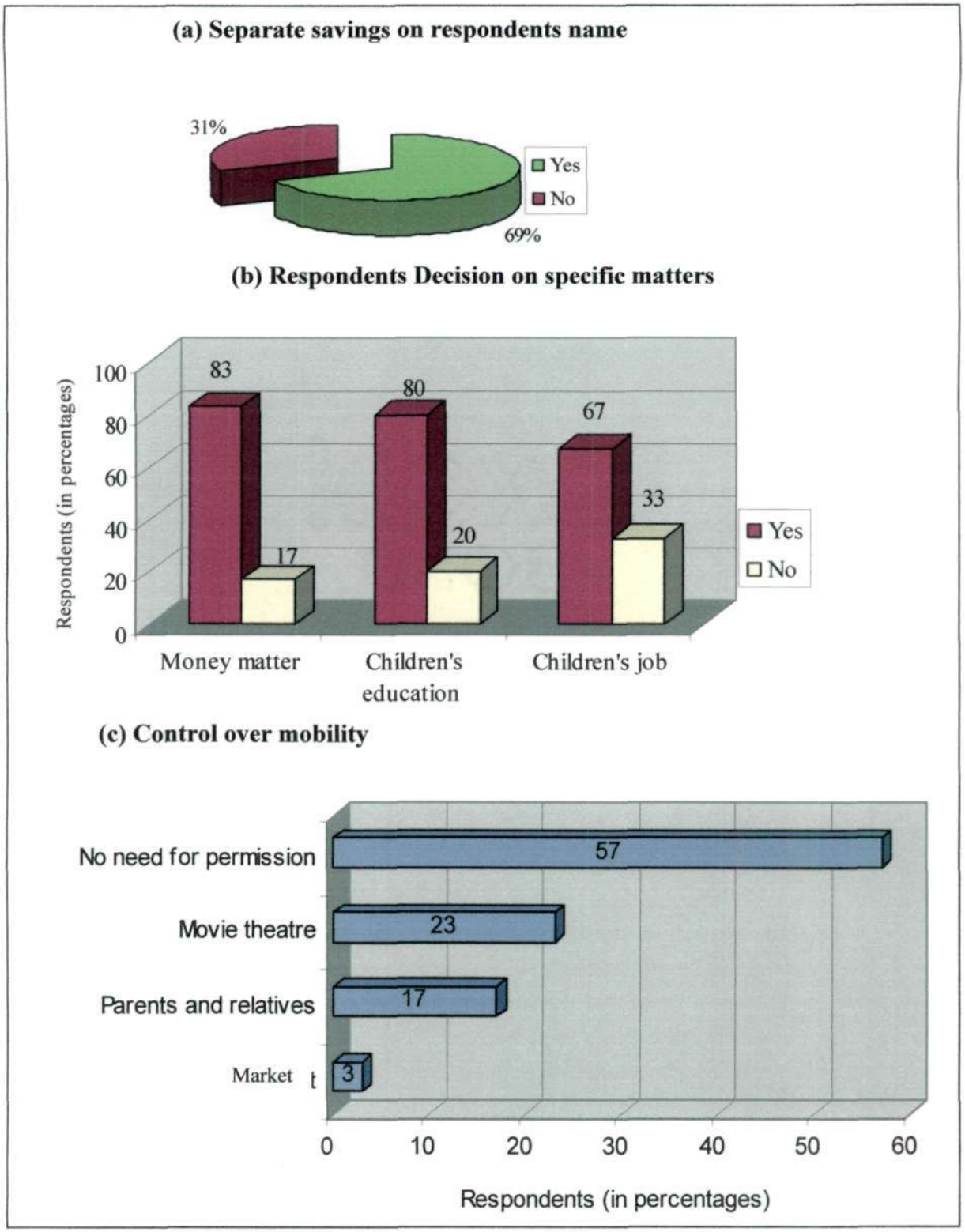
Source: Field Survey.

We can conclude that majority of respondents are found to have separate savings on their names. Here, we can mention that most of the respondents despite literate, earning and having a separate bank account are living a life subordinate to their male counterpart.

Respondents Decision on Specific Matters:

A perusal of table 4.43 and fig. 4.12(II) (b) shows the percentage distribution of respondents according to their decision on specific matters. As far as money is concern, the table reveals that 83.33 per cent of respondents contributed in decision-making on money matters while 16.67 per cent of them do not contribute anything. Concerning children's education, 80 per cent of respondents make decisions while 20 per cent respondents do not do so. It is also found that 66.67 per cent of respondents make decisions on children's job whereas 33.33 per cent of respondent's do not contribute anything on such decisions.

Figure 4.12 (ii): Decision-making Profile of Respondents



Source: Field Survey

TABLE NO. 4.43

DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THEIR DECISION ON SPECIFIC MATTERS

Decision on	Yes	%	No	%	Total/%
Money matter	250	83.33	50	16.67	300/100
Children's education	240	80.00	60	20.00	300/100
Children's job	200	66.67	100	33.33	300/100

Source: Field Survey

We can here conclude with the remark that majority of respondents make decisions on topics such as money matters, children's education and children's job. From this we can also sum up that majority of respondents are empowered, as they are able to contribute on such important matters. We can also say that all the women are not empowered because there are lots of them who are not able to take decision of their own and are enjoying living a dependent life.

Decision on the Items to Cook in the Family

A perusal of table 4.44 shows the decision of respondents on items to cook in the family.

TABLE NO. 4.44

PERCENTAGE DISTRIBUTION OF RESPONDENTS ON THE ITEMS TO COOK IN THE FAMILY

Responses	No. of respondents	Percentage
Yes	241	80.33
No	59	19.64
Total	**300**	**100**

Source: Field Survey.

It can be seen that majority of the respondents 80.33 per cent are able to decide while 19.64 of them are not able to make decision on the items to cook in the family. In sum, we can say that maximum number of respondents is able to cook on any items of their choice. To add to this, it is sad to know that some of the women 19 per cent have to cook according to the wishes of the family members only and she cannot cook as per her wish.

Control over Mobility:

A perusal of the table 4.45 and fig. 4.12(II) (c) shows the distribution of respondents on the permission needed for visiting certain places from husband and family members. It is revealed that more than half of the respondents 56.67 per cent of them do not need permission for going to market, visit parents and relatives and movie theatre. This shows their empowered status.

TABLE NO. 4.45
DISTRIBUTION OF RESPONDENTS (IN PERCENTAGES) ACCORDING TO THE PERMISSION NEEDED FOR GOING TO CERTAIN PLACES

Responses	No. of respondents	Percentage
Market	10	3.33
Parents and relatives	50	16.67
Movie theatre	70	23.33
No need for permission	170	56.67
Total	**300**	**100**

Source: Field Survey

The table also reveals that the rest i.e., a total of 46 per cent need permission for visiting or going such places as market, parents and relatives, movie theatre etc, indicating that they cannot do anything without permission from their family. So 46 per cent are not empowered. When they nee permission even to visit the mentioned places, one can clearly see that they would not be able to make decisions of their own on important matters related to their life. Such women used to inform their family whatever wherever there are doing or going and that also according to the wishes of the family.

Time for social contact:

A perusal of the table 4.46 and fig. 4.12(III) (a) shows that 75.33 per cent of respondents got time for social contact while 24.64 per cent did not get time for it. We can sum up here that majority of respondents have time for social contact.

TABLE NO. 4.46

PERCENTAGE DISTRIBUTION OF RESPONDENTS ON THEIR TIME FOR SOCIAL CONTACT

Responses	No. of respondents	Percentage
Yes	226	75.33
No	74	24.64
Total	**300**	**100**

Source: Field Survey

Other problems of women:

Awareness of respondents on AIDS, STDs, RTIs etc

A perusal of table 4.47 and fig. 4.12 (III) (b) shows that 98 per cent of the respondents are aware of Human Immunodeficiency virus/Acquired Immune Deficiency Syndromes (HIV/AIDS) while 2 per cent are ignorant about it. 66.67 per cent of them are also aware of Sexually Transmitted Diseases (STDs) while 33.33 per cent are not aware of it. It is also revealed that 76.66 per cent of the respondents are aware of Reproductive Tract Infections (RTIs) whereas 23.33 per cent of the respondents do not know about it.

TABLE NO. 4.47

PERCENTAGE DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR AWARENESS ON HIV/AIDS, STDs, AND RTIs ETC

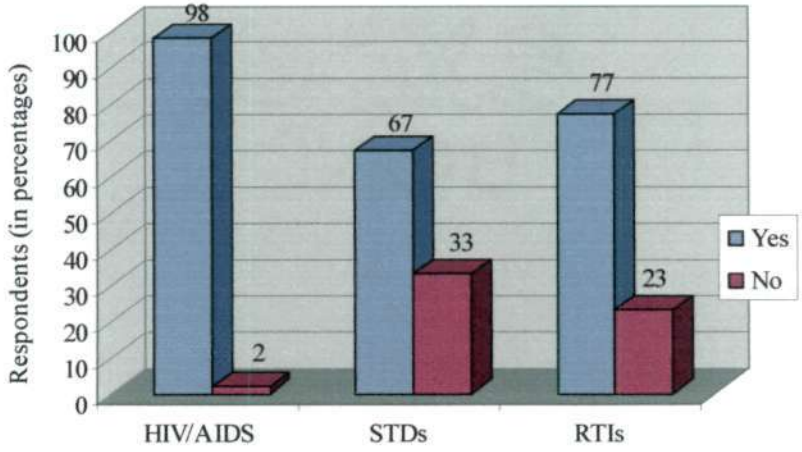
Awareness on	Yes	Percentage	No	Percentage	Total/Percentages
HIV/AIDS	294	98.00	6	2.00	300/100
STDs	200	66.67	100	33.33	300/100
RTIs	230	76.66	70	23.33	300/100

Source: Field Survey.

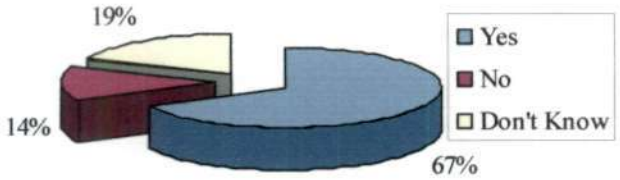
Figure 4.12 (iii): Decision-making Profile of Respondents

(a) Time for Social contact

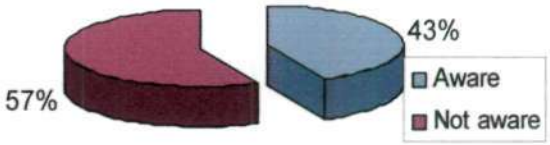
(b) Awareness of Respondents on AIDS, STDs and RTIs etc.



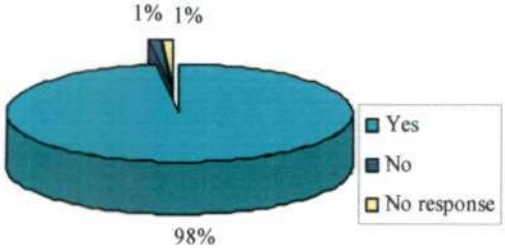
(c) Awareness of Respondents on AIDS



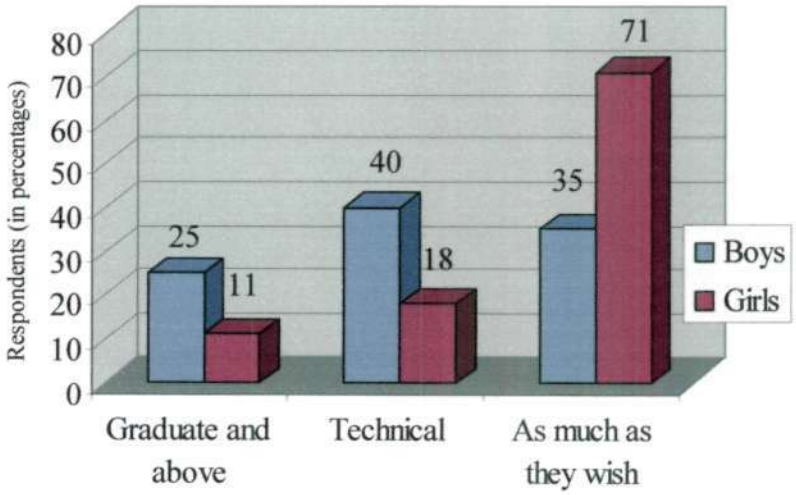
(d) Awareness of Respondents on the various governmental women programmes



(e) Permission needed to contest elections



(f) Opinion of Respondents on the levels of Children's (boys and girls) education



Source: Field Survey.

In sum, we can say that majority of respondents know about HIV/AIDS. One important reason why majority of them are aware is because HIV/AIDS is very much rampant in Manipur. Most of the families in Manipur lost a father, a husband, a brother, or a son because of HIV/AIDS, which is a big problem of the hour. That is why only 2 per cent of the respondents are found not having awareness on the said issue. However, regarding STDs and RTIs, many women are not aware of it at all which is a serious issue to be look into concerning their health.

Awareness of Respondents to Avoid AIDS:

A perusal of the above table 4.48 and fig. 4.12(III) (d) shows that 67 per cent of the respondents are of the idea that AIDS can be avoided while 13.67 per cent think it otherwise and 19.33 per cent of them have no idea about its avoidance. In conclusion, we can say that majority of respondents think that AIDS can be avoided while the rest do not have idea. When majority is having awareness on what AIDS is, they do not know much about its avoidance. There is an urgent need to give those women who lack knowledge about its avoidance in order to stop the further spread of HIV/AIDS.

TABLE NO. 4.48

PERCENTAGE DISTRIBUTION OF RESPONDENTS ON THEIR AWARENESS TO AVOID HIV/AIDS

Responses	No. of respondents	Percentage
Yes	201	67.00
No	41	13.67
Don't know	58	19.33
Total	**300**	**100**

Source: Field Survey.

Awareness of Respondents on the Various Governmental Programmes Available for Women:

A perusal of the above table 4.49 and fig. 4.12(III) (d) shows that 57.33 per cent of the respondents are not aware of the various governmental programmes available for women while 42.67 per cent are aware of it. This shows that the Government of India's plan and programmes specially meant for the empowerment of women is not reaching the marginalised section of women.

TABLE NO. 4.49

PERCENTAGE DISTRIBUTION OF RESPONDENTS ON THEIR AWARENESS ON VARIOUS GOVERNMENTAL PROGRAMMES AVAILABLE FOR WOMEN

Levels of awareness	No. of respondents	Percentage
Aware	128	42.67
Not aware	172	57.33
Total	**300**	**100**

Source: Field Survey

In sum, we can say that maximum number of respondents is not aware of the various governmental policies and programmes specially meant for women. This will act as a hindrance for women from achieving the necessary health care and services.

Respondents' Need to Take Permission from Husband and Family Members to Contest Elections:

A perusal of table 4.50 and fig. 4.12(III) (e) shows that according to the respondents 89 per cent of them needed permission if they wish to contest elections while 8.67 per cent did not need so and 1.66 per cent did not give response on it.

TABLE NO. 4.50

PERCENTAGE DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR OPINION ON THE NEED FOR PERMISSION FROM HUSBAND OR FAMILY MEMBERS TO CONTEST ELECTIONS

Responses	No. of respondents	Percentage
Yes	269	89.67
No	26	8.67
No response	5	1.66
Total	**300**	**100**

Source: Field Survey

It can be concluded that majority of respondents will need permission if they want to contest elections that clearly indicates that women are powerless and are dependent on their male counterpart in every step of their life.

Opinion of Respondents on the Levels of Education to be given to their Children (boys and girls):

A perusal of table 4.51 and fig. 4.12(III) (f) shows the opinion of respondents on the level of education that should be given to their children (both boys and girls). As far as boys are concern, 35.33 per cent of respondents would give freedom to the male child to learn as much as they wish while it is 71 per cent for girls, 39.67 per cent are in favour of technical education (boys) and its 18.33 per cent for girls and the remaining 25 per cent of respondents are of the idea that boys should be educated in general line i.e. up to graduation and above and it is 10.67 per cent for girls.

Here we can conclude that majority of respondents give freedom to their children as much as they wish to do. This table thus reveals that there is no discrimination against the girl child in terms of education of the children

TABLE NO. 4.51

PERCENTAGE DISTRIBUTION OF RESPONDENTS ACCORDING TO THEIR OPINION ON THE LEVELS OF EDUCATION TO BE GIVEN TO THEIR CHILDREN (BOYS AND GIRLS)

Levels of education	Boys	Percentage	Girls	Percentage
No education	-	-	-	-
Primary	-	-	-	-
Middle	-	-	-	-
High school	-	-	-	-
Higher secondary	-	-	-	-
Graduate and above	75	25.00	32	10.67
Technical	119	39.67	55	18.33
As much as they wish	106	35.33	213	71.00
Total	**300**	**100**	**300**	**100**

Source: Field Survey

.This chapter has focussed on many issues relating to the reproductive health of women in the reproductive age group in Manipur. Women are found to have low socioeconomic status. Important revelations regarding the health status of women shows that majority is health conscious and has awareness regarding contraception, HIV/AIDS etc. Majority of the respondents going for antenatal and post natal care proves it. At the same time, a shocking revelation is that most of them are found to visit doctor only when their illness is serious. Further, it is found that despite the respondents being literate, there are number of women who indulge in unhygienic practices (menstruation), believe in certain myths that diseases can be cured by priest or traditional healers and offering to gods and goddesses and so such women with this belief keep themselves away from consulting doctor. The greatest barrier to these women is poverty combined with carelessness and lack of proper knowledge and decision making power that may lead to serious health consequences. It is also shocking to know that when majority of the women are literate, earning and contributing to their family; they are having little say in important areas of decision making such as sexual life, use of contraception, number of children she wish to have in future, permission in

consulting doctors and visiting relatives, etc. Chatterjee posits five barriers that stand between women and their access to health care services such as need, perception of need, permission, ability and availability [7]. These barriers are either directly or indirectly controlled by the family and are often denied to women in various societies.

To sum up, we can say that despite the government policies and programmes, majority of women in Manipur are not empowered and not receiving the health services well. However, there are also women who are empowered and enjoying an independent and healthy life because of their high socio-economic position. So until and unless women realise their subordinate position and know their values, they would not be able to break away from the various restrictions and the dependency that the traditional system of society has to offer.

References

1. Cochrane, Susan, (1980), The Effects of Education on Health, Staff Working Paper No. 405, World Bank, Washington, D.C.
2. Caldwell, J. C and McDonald, (1981), Influence of Maternal Education on Infant and Child Mortality: Levels and Causes, Paper Presented at the IUSSP Conference, Manila, 1981, Vol.2, pp. 79-96.
3. Women and Men in India, (2001), Central Statistical Organisation, Ministry of Statistics and Programme Implementation, Government of India.
4. Mittal, Suneeta, *et. al.*, (2003), Socio-Demographic profile of Emergency Contraceptive Users, Journal of Family Welfare, Vol. 49, No. 2, December.
5. Khan, M. E. and C. V. S. Prasad, (1983), Family Planning Practices in India- Second All-India Survey, Operations Research Group, Baroda.
6. Chatterjee, Meera, (1990) 109, Word Bank Discussion Papers, Indian Women: Their Health and Economic Productivity, the World Bank, Washington, D. C.S
7. Chatterjee, 1991, Gender and Poverty in India, Word Bank, Washington.

CHAPTER V
SUMMARY AND CONCLUSION

CHAPTER V

SUMMARY AND CONCLUSION

The basic premise of the study has been that empowerment of women not only affects health of women themselves, but it also results in greater health benefits to their children, families and ultimately leading to the overall social development of the society. Healthy human beings are central to development because investments in health can translate into healthier men, women, and children and increased capacity to lead socially and economically productive lives. Children who are healthy grow and learn better and have an improved chance of developing the skills necessary for employment. Illness or the death of a household head can lead to family crisis and a vicious cycle of ill-health and poverty.

Available literature also suggest that empowerment strategies or interventions had important health related outcomes such as improved self-efficacy and self-esteem, greater sense of control, increased knowledge and awareness, behaviour change, a greater sense of community, broadened social networks and social support.

The International Conference on Population and Development, 1994 and the Fourth World Conference in Beijing, 1995 specially identified empowering women as an essential ingredient for achieving desirable reproductive health and population outcomes. Yet, more than a decade later, this part of the Cairo and Beijing agendas remains largely unfulfilled. Women continue to suffer from persistent inequalities. Inequalities in health in a society are the outcome of unfair distribution of power between different groups within that society. Power relations within a society influence the distribution of resources and the development of policy. This is why economic development and changes in health care system by

themselves have not been able to enhance the health status of marginalised groups to the extent desired.

Research on women's status has found that the health of Indian women is intrinsically linked to their status in society. Indian society since its inception was built on the principle of inequality where women are given a raw deal in society. Indian women have been enjoying a subordinate position in society and they have been living under the control of first their fathers, then their husbands and finally their sons. The culturally preference for sons sometimes results in the mistreatment of the daughters and the triple burden placed on young women – reproduction, domestic work, and productive labour have a negative impact on the health status of women in India.

It is in this context, the present study focused on women's empowerment particularly on women's health - their freedom from control by other family members and ability to affect desired outcomes within the household. It aimed to examine the linkage between women's empowerment and social development. Though, the main purpose of this study has been to understand the empowerment of women, adolescent girls are also included in this study. This is because adolescent girls constitute the most important stage in a woman's life and they form the initial reproductive age group. Thus, the present study has been to explore the empowerment of adolescent girls and women in terms of their reproductive health within the socio-cultural context of Manipur.

Both primary and secondary sources are used extensively in the present study in order to provide an objective empirical support to the study. This study is exploratory-cum-diagnostic in nature. The present study has taken up two districts of Manipur, namely, Imphal East and Imphal West as the area of study. Assessment of the health of women in both the Imphal East and Imphal West districts is done with the help of field surveys. The investigator studied the health and developmental needs of 400 respondents, viz., 100 adolescent girls (11-19

years age group) and 300 women in the reproductive age group (15-49) belonging to different social strata by adopting the multistage stratified random sampling. Separate structured interview schedules are used to collect information from adolescent girls and women respondents.

Summary and implications of the findings

The demographic background of the study area shows that the total geographical area of the state is 22,327sq.km with a total population of 23, 88,634 (males: 1,207,338; females: 1,181,296 in 2001 Census). The sex ratio in Manipur is 978. The literacy rate is 68.87 percent and male percentage is 77.87 where as female is 59.70 per cent.

Findings on Adolescent girls

Available literature suggests that adolescence is a critical period in a woman's life-cycle. Despite the critical importance of the adolescent period in a woman's life, until recently, little effort has been made to accurately address and analyse the specific conditions and needs of adolescent girls with an aim to redress the situation.

To empower adolescent girls means to give adolescent girls a voice to speak their desires, emotions and experiences. The first step towards empowering adolescent girls is to recognise their specific needs and situation. Empowering girls means helping to empower and educate the next women and mothers in the society. An empowered girl will be able to express their creativity and develop self-esteem and self-confidence.

However, the situation of adolescent girls is particularly complex because deep-rooted traditions of patriarchy and the subordination of women and girls, make it difficult for adolescent girls to realise their rights in many parts of the world. Their lack of awareness on their health care, reproductive health, sexual

activity and substance use leads to a risky future health condition. Many rightly describes the period of adolescence as the period of 'storm and stress'.

The findings regarding adolescent girls in Manipur shows that they need to go a long way to see them as empowered. This is despite the various available Governmental Policies and Programmes. They continue to be included in the category of either women or children in most of the policies and programmes (discussed in Chapter II). So, girls are not benefited much by these said policies and programmes.

Discrimination is seen in different forms in case of Manipur also. Preference for sons exists in the region, discrimination against girls as it does throughout the country. Girls are always expected to help their mother in the household work when only some of respondents' brothers do so. Girls' work responsibilities at home often increase as they get older. Earlier research studies found that heavy workloads at home can keep most girls out of school. However, one important finding is that no discrimination in terms of education, food, etc. can be seen. Though young girls are not always deprived of the attention and care she needed most, they are often found to be regarded a burden on their families and have poor self-image as compared to their brothers. Adolescent girls have been mainly socialised to care for others rather than themselves.

What is being observed is that all the girls are educated and the parents make no restrictions towards educating their girl child. However, the statement mentioned earlier seems to bear no fruit, which said education is a key aspect for the empowerment of adolescent girls so that they can express their creativity and develop self-esteem leading to improve health and quality of life. While there has been considerable improvement in the education of girls, the probability that adolescent girls will drop out of school is still significant. In the present study, it is found that even though the girls are educated they cannot raise their voice much against their parents. They feel that whatever is happening is natural and so as

always expected, they help their parents in the household chores while it is not always so in case of their brothers.

As far as their awareness level is concerned, in some areas the awareness level of the girls is high whereas in some it is low. One finding is that high percentages of girls are aware about the onset of menstruation. Here, mother plays an important role in providing the necessary information. The other sources of information are sisters, friends, and books, etc. Menstruation is regarded as an important factor for psychological stress among adolescent girls because it may be very upsetting event for some girls who are not prepared for it. The result shows this fact also, those girls who are not given prior information before its onset do suffer from psychological stress, for example, they complained to suffer from discomfort, disgust and are even scared to see blood flow for the first time. This problem if not look into in time may create further health problems to the young girls. They are also vulnerable to infections if prior information about hygienic practices regarding menstruation is not given. There are certain myths and taboos associated with menstruation. While the girls are very knowledgeable about the myths and taboos, they have little knowledge about the biological processes of maturation and normal physiology. However, good number of them is found following certain myths that forced them from taking nutritional food they need to take during menstruation. To add to this, young girls also lack information on hygienic practice during menstruation, which consequently may increase susceptibility to various infections.

Another important factor for psychological stress among adolescent girls is lack of knowledge on physical change that has taken place due to the onset of puberty. Their level of awareness regarding the physiological changes is found to be not that high. More than half of the girls are unaware and uninformed about the physical changes. Bodily changes play an important role in the overall development of adolescents. But, parents who are regarded as the most important

source of information for their children fail to prove. Here, we can see clearly the communication gap between the parents and their children. As discussion on sexuality is absent in Manipuri society, young girls are not prepared mentally for the physical changes. Thus, they began to have psychological problems, such as, they are emotional, have a lower self-image and suffer from depression, anxiety and disordered eating, etc. This deeply affected their interests, their social behaviour and the quality of their affective life, which may deteriorate their health condition and may have long lasting effect.

Further, it is clear from the study that most of the girls in general are aware of the basic knowledge of contraception, pregnancy, and childbirth, RTIs, STIs, and HIV/AIDS, etc. Almost all the girls have reported that they have awareness. But still a few of them are ignorant that may prove to be risky for their future life, if this need is not addressed properly. AIDS prevention may largely depend on health education and behavioural changes based on their awareness on contraception, pregnancy, and childbirth, RTIs, STIs, and HIV/AIDS, etc, particularly among the young girls who are more prone to risky behaviour.

Findings on women

Studies have found socio-economic background has an important bearing on accessing health care facilities and awareness about health and disease. For example, women experiences more problems in accessing health services, often due to poorly designed and/or shrinking health infrastructures, socio-economic hardships, and geographic barriers (e.g. distance lack of public transportation, etc.). Women also often suffer from ill health due to a lack of health education. Men enjoy a greater degree of social freedom compared to women. Women are subjected to more social restrictions than men of the same age, especially after they attain puberty. Available literature suggests that restrictions in social mobility

are more common in the villages than in cities and, perhaps, this contributes to the lower knowledge levels among women.

The findings on Manipuri women reveal many issues relating to their socioeconomic background, their reproductive health needs, level of awareness regarding contraception, decision-making of women, etc.

In the present study, the socio-economic background of women includes age, religion, education, marital status, age at marriage, employment husband's background, place of residence, etc. The data related to these factors provide an understanding of empowerment of women in relation to the awareness levels in terms of health, particularly reproductive health.

In the present study, the average age of the women respondents is 27 years, majorities are Hindus, literate and one third of them are graduates. As most of the respondents are literate, it may be a reason why early marriage is not found in the study area. There is a growing consensus now that education, irrespective of who receives it, contributes to development. Though, most of the women are found to be literate, only few of them continued for higher studies. Thus, they need to be educated further because it is now widely recognised that education is a key aspect for the empowerment of women and higher the education, higher would be the possibilities of raising income and age at marriage, improve health and quality of life. Education is a powerful vehicle for women's equal access to knowledge, skills, jobs and participation in society.

It is found that majority of the women are presently living with their husbands. A small percent of them did not live with their spouse as they are separated; a few of them are divorced and widowed. Though divorce is not common in the study area, many women used to live even with an abusive spouse thinking that it is natural. These show their weakness and helplessness.

Family structure is relevant in the discussion of empowerment. As many of the questions relate to domestic decisions making to establish empowerment levels, family structures can influence the responses. The traditional family structure in India is not a nuclear family, it a joint family. In this system, when a son marries, he continues to reside with his parents, with his wife and their children. The daughter, on the other hand, goes to her husband's home and lives with his parents, unmarried siblings, and the families of his married brothers. The parents of the husband in a joint family tend to hold decision-making authority that often overrides the authority of any of the married sons or their wives. However, in the present study, the number of joint families is found to be low, only one third of women in our study live in traditional joint families, whereas the rest lived in a nuclear family setting.

Looking into husband's background reveals the difference in the literacy rate between male and female. Though we can see more or less the same occupational structure, husbands are earning more than the respondents. Husbands' background also reveals that most of the respondents belong to middle class families because majorities do not earn a steady income. In this study area, alcoholism and gambling is rampant, so the respondents were asked if they had problems related to alcohol consumption. It is found that a little more than 21 per cent suggested that they had experienced problems related to the alcohol consumption by their husbands. This ranged from beatings and the use of household money for alcohol. What is surprising is that some of the women regarded their husbands' brutality as manly, thus taking it as natural. This condition of women and their ignorance may have bad health consequences.

The respondents' economic status reveals that majority are doing the double burden of earning along with the household work. Most of them are found to be working on their own choice, some because of poverty while others as per wishes of their husband. More than half of the women who are earning are found

to be engaged in agriculture, wage earner, shopkeepers, etc, while some of them are found to be in service and more than 60 per cent are contributing to the family income. However, this formula for supporting Manipuri families leaves little resource for the growth and development of women's rights and educational levels. It is also revealed that majority of them are not earning a steady income, so some of them still depend on their families for economic needs. Another important revelation is that when majority of the women are literate, earning and contributing to their family; they are having little say in important areas of decision making such as sexual life, use of contraception, number of children she wish to have in future, permission in consulting doctors and freedom in mobility, etc.

Important revelations regarding the health status of women shows that majority is health conscious and has awareness regarding contraception, HIV/AIDS, etc. A maximum number of them going for antenatal and post natal care prove it. At the same time, another shocking revelation is that most of them are found to visit doctor only when their illness is serious. Further, it is found that many of them have some gynaecological problems. Women, who lack knowledge indulge in unhygienic practices and beliefs related to menstruation, believes in certain myths like diseases can be cured by priest or traditional healers and offering to gods and goddesses. So, such women with this belief do not consult doctor. The greatest barrier to their problem is poverty combined with carelessness and lack of knowledge compelling them to various beliefs and practices that may lead to serious health consequences.

The decision making power of respondents is examined to explore their freedom from control by other family members relating to their everyday life and their ability to affect desired outcomes within the household. Findings from the present study show that men have dominant power and authority over women regarding the decision making. This study also highlights that the rights of

decision making related to family planning and other matters go to the husband's authority. Most of the literature available also suggests that one of the important means of women's empowerment is to be able to choose life partner of their own choice. This present study highlighted that women are able to choose life partner of their own liking. Another striking revelation is that most of the women take this decision as it has been carrying on since the past. Even if parents come in between, they used to elope with their lovers against their parents wishes. What is important to note here is that having a right to choose life partner does not mean that they are having decision making power. Because marriage by elopement is in their favour, as it is very much practice in Manipur.

Testing of Hypotheses

1. *The first hypothesis states that women of Manipur are empowered right from adolescence period.*

Findings from the present study (Chapter III) reveal that adolescent girls in Manipur cannot even raise their voice in their family. They are found to have low self-esteem and low self-confidence as compared to their brothers as a result of indifferent treatment of parents towards their children. 40 per cent (Table no. 3.4) of adolescent girls reported receiving differential treatment from their parents. It is further revealed by this study that all (100 per cent) the girls are found helping their parents in the household chores, whereas 31 per cent (Table no. 3.5) of the respondents' brothers do not do so.

To add to this, it is also clear from this study (Chapter III) that adolescent girls are not provided the required health and developmental needs. All the girls in this study are educated, despite this they are compelled to practice certain beliefs and practices regarding their health, particularly relating to menstruation. An unhygienic practice that can be seen is the use of cloth during menstruation and to reuse it for the next menstruation, after washing it and keep it in a place out of

sight of the male members of the family. 43 per cent (Table no. 3.10) of the girls are found following this practice. 78 per cent (Table no. 3.13) reported taking care in their diet during menstruation. Here, taking care in diet means following certain myths of avoiding to eat some specific fruits and vegetables (Chapter II), that will make their complexion worse and may also suffer from other health problems. This shows their lack of awareness on health care and so they do not receive the available services.

Fifty five per cent of the girls (Table no. 3.17 in Chapter III) also lack knowledge on reproductive health- physical changes that take place on the onset of puberty. This greatly affects their mental developments (Table no. 3.19). Even the parents (Table no. 3.18), who are regarded as the most important source of information provider for their children, rarely talk with their children on sex related issues. This is mainly because talking about sex related things is a taboo in Manipuri society. As discussed earlier (Chapter II), various studies agree that adolescent girls' lack of awareness on their health care, reproductive health, sexual activity and substance use leads to a risky future health condition. Thus, the data did not support the first hypothesis and hence the first hypothesis is rejected.

2. *The second hypothesis states that women of Manipur are empowered till their last breath in socio-economic spheres.*

In this study, available literature (Chapter II) shows that Manipuri women have a high social position in the past and Manipuri women are described as very industrious while men are described as lazy and indolent. This hardworking nature of women can be seen till today as 76 per cent of the respondents (Table no. 4.15 under Chapter IV) in this present study are earning and 90 per cent (Table no. 4.19) are contributing in some way or the other to their family income. But 60 per cent (Table no. 4.17) of women are not earning a steady amount as most of them are daily wage earners (Table no. 4.16), so they are still dependent on their families for other economic needs.

The reason for women earning a minimal amount is because women are not highly educated. Only six per cent are found to complete post graduate (Table no. 4.3 in Chapter IV). So, we can say that women are not having high socioeconomic status. The second hypothesis is therefore rejected.

3. *The third hypothesis states that women of Manipur due to lack of awareness have different attitudes and practices regarding health which caused imbalance in the sex ratio.*

In this study (Chapter IV), women are found to have lack of knowledge and so (73 per cent) indulge in unhygienic practices particularly relating to menstruation (Table no. 4.20). They also believe in certain myths, like diseases can be cured by priest or traditional healers and offering to gods and goddesses (Table nos. 4.21, 4. 23 and 4.36) and so such women with this belief do not consult doctors. Most of them (65 per cent Table no. 4.37) are found to visit doctors only when their illness is serious. However, the data of the Imphal West, one of the two present study areas shows that females outnumbered males. The sex ratio in the Imphal West district is 1004 females per 1000 males (Chapter I). Thus, it can be said that different attitudes and practices regarding health due to lack of awareness on the part of women, caused imbalance in the sex ratio is incorrect. Thus, the hypothesis number three is partially tested.

4. *The fourth hypothesis states that Manipuri women are having knowledge of contraceptive methods but its use is low due to their concern about possible side effects.*

It is found in the present study (Chapter IV), that 87 per cent (Table no. 4.28) women are having awareness of the various available contraceptives and sterilisation is the method which most of them 43 per cent (Table no. 4.28) have heard about. As shown in table no. 4.29, of the total women who are currently living with their husbands, 47 per cent of them are not using any contraceptives. Copper – T (17 per cent), condom (14 per cent), pills (13 per cent), sterilisation (6

per cent) and the least periodical 1 per cent) are the methods which the rest of the respondents are currently using. However, what is striking is that among the users also, about 60 per cent (Table no. 4. 30) wish to discontinue its use because they complain of having side effects such as weight gain, infertility, unwanted pregnancy, breast cancer, birth defect, etc. Some of the women reveal being disapproved by their husbands. Thus, it can be concluded that the evidence supports this hypothesis.

5. *The fifth hypothesis states that Manipuri women who are economically independent are able to have their partners of their choice and are free to decide on the number of children they want.*

In the present study, the data shows (Chapter IV), the tradition of marriage by elopement is in the favour of women because it is still very much in practice in Manipur. So, women 77 per cent (Table no. 4.34) of them are able to choose life partner of their choice. However, the data also indicates that women have little say in important decisions on the number of children woman wish to have in future. Only 11 per cent (Table no. 4.38) are able to make this decision. Further 24 per cent (Table no 4.35) of women are able to take their children to a doctor without consent. Thus, we can say that though women have the right to choose their life partner of their liking, the decision of the number of children she wants to have in future is not in their hands. Hence, hypothesis fifth is partially accepted.

6. *The sixth hypothesis states that Manipuri women are well aware about the illness of HIV/AIDS but knowledge to avoid it is low.*

In the study area, a matter of concern is the spread of HIV/AIDS among the general population, particularly among women, whose chances of contracting the virus were once considered low. In this study (Table no. 4.47 in Chapter IV), 98 per cent of women have reported that they have heard about HIV/AIDS, STDs and RTIs, etc whereas only 2 per cent women reported that they have no knowledge about HIV/AIDS. However, what is striking in the present study is the poor

knowledge of a considerable proportion of women (32 per cent shown in Table no. 4.48) who does not know whether there is a cure for HIV/AIDS or not. So, the sixth hypothesis is accepted.

7. *The seventh hypothesis states that majority of women in Manipur are not aware of the women oriented governmental programmes and hence fail to benefit from such programmes.*

Fifty seven per cent of women (shown in table no. 4.49 under Chapter IV) are unaware of the said programmes and the findings of this study show that despite the available government policies and programmes, women's health needs remains largely unfulfilled. One important reason is the outcome of unfair distribution of power between different groups within that society. Power relations within a society influence the distribution of resources and the development of policy. This is why economic development and changes in health care system by themselves have not been able to enhance the health status of marginalised groups to the extent desired. So, large gaps still exist in almost every sphere of women's life, which do not empower women to have informed choices on their health. Empirical studies also show that women suffer most of the brunt of their subordinate status due to persistent inequalities and relative powerlessness. Thus, it can be concluded that the evidence supports the seventh hypothesis.

Conclusion

The new millennium has thrown many challenges subjugating many nations to undergo transformation getting across their established tradition and culture. New issues have to be addressed to achieve social and economical progress. Health, education and other essential services form the fundamental grounds of change, lifting the people from poverty and powerlessness and leading to greater democratisation in development and political empowerment. They also lay the foundations for a sustained and equitable economic growth of any country.

Women empowerment is one of the important issues of contemporary development policies. However, large gender gaps still exist in almost every sphere of life, which do not empower women to have informed choices on their health and nutrition. Empirical studies show that everywhere in the world, women suffer most of the brunt of poverty and abuses due to persistent inequalities and relative powerlessness.

The patriarchal functioning has ensured that health for women normally means maternity services, excluding basic health services that lie at the root of many a problem. However, women are the vital infrastructure and their empowerment in respect to their health would hasten the pace of social development. Investing in women's capabilities and empowering them to achieve their choices and opportunities is the definite way to contribute to the economic growth and the overall development. The empowerment of women leads to benefit not only to the health of the individual women but greater health benefits also to their children, families and ultimately leading to the overall social development of the society.

The United Nations reported in their report 'Enabling Environment for the Empowerment of Adolescent Girls' that 'despite widespread progress in improving the health, nutrition and education of children, the situation of girls continues to be disadvantaged compared to that of boys in many parts of the world'.[1] Worldwide, approximately 500 million children start primary school, but more than 100 million children, two thirds of them girls, drop out before completing four years of primary school. Girls are not encouraged as much as boys to further their studies and develop their careers.

Adolescents are the future population, so, the need of the hour is to provide especially adolescent girls, the right knowledge and awareness about their health and developmental needs. The health of the women of tomorrow is critically dependent on the health of the children of today. While the girl child benefits from

a number of biological advantages in terms of her survival and health, she also faces social, cultural and gender based disadvantages that place her health at risk. Many of the health problems faced by adult women have their origins in childhood and during adolescence.

Home is the place where socialisation of a child begins, and where the biggest change can happen about the empowerment of the girl child. Mothers and fathers, and guardians alike, need to be made aware that both girls and boys are equal and that no preferential treatment should be given to any of them.

The activities of the adolescent girls programme should include: health education, personal development, group discussions about attitudes, self-defense lessons, and creative activities and media responsibility with regard to adolescent girls' health. The health care providers also need to be sensitised to women's health issues. Issues such as quality of services, long waiting hours, and lack of female practitioners and apathy of physicians towards women clients ought to be addressed mutually by the state, NGOs, health care providers and the community. Public information campaigns can be organised with the media taking a leading role in order to eliminate negative cultural attitudes and practices against girls and women to achieve gender equality within the society.

We can say despite the government policies and programmes, majority of women in Manipur are not empowered and not receiving the health services well. Though some of them are seen having the power, most of the women are not. This affects their health conditions. In the study area, the culture and traditions provide the right and power to male members in the family, to make a decision of the whole things about the women whether male is her father, uncle, brother or husband. The contributing factors that have maintained gender discrimination and the low health status of women in Manipur include: their socioeconomic status and situation, differential treatment towards children, insufficient knowledge and lack of awareness regarding their reproductive health, different attitudes and practices

relating to health care, and lack of decision making power on important areas that affect their health. Various literatures also show that patriarchal ideology and systematic gender discrimination have deprived women from equal opportunities regarding educational, health care services, access to and control over resources, social welfare, and support.

Nevertheless, one of the basic policy objectives should be education of woman, the lack of which tends to perpetuate the unequal status and other socio-economic problems. At the end, it is concluded that women empowerment which is declared as Millennium Development Goal by UNDP, could be achieved only when all concerned bodies work in co-operation and understanding the factors analysed in this study. The society as a whole has to understand women's capabilities and their contributions to the developmental process. Empowering Women is an important end in itself not only as human right issue but also as having the potential to enhance human well being. Empowering women and improving their health status are essential ingredients for realising the full potential of the economic and potential development of the entire society thus ensuring social development.

Limitations

Notwithstanding the strengths of the study, there are a few limitations. For instance, the study could not cover a large sample representing all women in Manipur. Thus, there is a need for further research on a larger scale in the state. It may be noted that there is also need to further explore the socio-cultural differences among different ethnic categories of people of Manipur for further insights. Within the health context, information on women's health in Manipur is unsatisfactory from many points of view. Health statistics in general are poor resulting in a lack of reliable state data.

Suggestions for further research

As the term empowerment is multifaceted and multidimensional, further indepth qualitative study need to be carried out on other relevant variables such as the sexual behaviour and beliefs. This would provide greater insights for the empowerment of adolescent girls and women. Some other studies that may be done to gain better insights into the health needs of women are being outlined hereunder:

i) Adolescent girls and their sexual behaviour, attitude and belief

ii) Women and men: comparative study of their sexual behaviour, attitude and beliefs relating to health.

iii) Comparative study of the reproductive health needs between adolescent girls and women.

iv) Comparative study between the health needs of women of Manipur in particular and women of India in general.

v) Comparative study of health needs of men and women.

For carrying out such research, there is a need to look at women's health in all its dimensions-physical, emotional and social well-being. Adolescents must be recognised as a separate target group instead of categorising them under other groups like women or children. Researchers and planner should devise and implement preventive programmes regarding women's health and ensure sufficient funding for women's health care services.

References:

[1] United Nations Division for the Advancement of Women, (1995), Enabling Environment for the Empowerment of Adolescent Girls. www.uneca.org/eca_resources/Publications/

BIBIOGRAPHY

Abraham, Leena, (2001), Understanding Youth sexuality: A Study of College Students in Mumbai City, The Indian Journal of Social Work, 62(2).

Al Riyami A.A., M. Afifi and R. Mabry, (2004), Women's empowerment in Oman and its influence on contraceptive use. Reproductive health matters 12:23, p. 144–54.

Allendorf, K. (2007), Do Women's Land Rights Promote Empowerment and Child Health in Nepal?, World Development 35 (11): 1975-1988.

Alsop, R., Bertelsen, M. and Holland, J. (2006) Empowerment in Practice: From Analysis to Implementation, p.10, Washington, D.C., World Bank.

Amin Rahul, Becker Stan and Byes Abdul, (1998), NGO-Promoted Micro credit Programs and Women's Empowerment in Rural Bangladesh: Quantitative and Qualitative Evidence, The Journal of Developing Areas, Winter, 221-236.

Bakshi S.R, Kiran Bala, (2000), Social Status and Role of Women, Deep and Deep Publications Pvt. Ltd. New Delhi, P-185.

Bansal, R.D and Mehra, M, (1998), Adolescent Girls: An Emerging Priority, Indian Journal of Public Health, 42(1), 1.

Bathliwala, Srilatha, (1994), The Meaning of Women's Empowerment: New Concepts from Action, In Population Policies Reconsidered: Health, Empowerment, and Rights, Gita Sen, Adrienne Germain, and Lincoln Chen (ed.), Cambridge, MA: Harvard University Press.

Betteile, Andre, (1999), Empowerment, Economic and Political Weekly, March 6-13.

Bezbaruah, Supriti and Janeja, Mandeep. K, (2000), Adolescents in India: A Profile, UNFPA for UN system in India, www.un.org.in/adolescentsfinalbook-800kb.pdf (11.02.07).

Bilance, (1997), A world in balance - Bilance stands for Social Development: Policy paper, Oegstgeest, September.

Black, Maggie, (1994), Girls and Women: A UNICEF Development Priority, New York, 1994, pp. 23.

Blos, Peter, (1962), On Adolescence, A psychoanalytical Interpretation, Glencoe, Inc. U.S.A.,

Bowlby, J, (1953), Child Care and the Growth of Love, Penguin Books, Harmondsworth.

Brattesani, K and Silverthorne, C. P, (1978), Social Psychological Factors of Menstrual Distress', Journal of Social Psychology, 106, 139-140.

Bullough, V.L, (1981), Age at Menarche: A Misunderstanding, Science, 213, 365-366.

Caldwell J. C. and P. Caldwell, (1993), Women's Position and Child Mortality and Morbidity in Less Developed Countries, Pp. 122-139 in Women's Position and Demographic Change, edited by N. Federici. K. O. Mason, and S. Sogner. Oxford: Clarendon Press.

Caldwell, J. C and McDonald, (1981), Influence of Maternal Education on Infant and Child Mortality: Levels and Causes, Paper Presented at the IUSSP Conference, Manila, 1981, Vol.2, pp. 79-96.

Census of India, (1991), Registrar General and Census Commissioner 1991, Government of India.

Census of India, (2001), Directorate of Census Operations, Manipur.

Centre for Development and Population Activities, CEDPA, (2001), Adolescent Girls in India Choose a Better Future: An impact Assessment. www.cedpa.org/content/publications/detail/634.

Chandra, Shanti Kohli, (1997), Women and Empowerment, Indian Journal of Public Administration, July-September, Vol.XLIII. No.3.

Chatterjee, 1991, Gender and Poverty in India, Word Bank, Washington.

Chatterjee, Meera, (1990) 109, Word Bank Discussion Papers, Indian Women: Their Health and Economic Productivity, the World Bank, Washington, D. C.S

Cochrane, Susan, (1980), The Effects of Education on Health, Staff Working Paper No. 405, World Bank, Washington, D.C.

Cole, Leulla, (1962), Psychology of Adolescence, Holt, Rinehart and Winston, New York (fifth edition), 89.

Crow, Lester. D and Crow Alice, (1956), Adolescent Development and adjustment, McGraw, Hill book Company, Inc. New York, Toronto, London, 387.

Dasgupta, Monica, (1987), Selective Discrimination against Female Children in Rural Punjab, India, Population and Development Review 13(1): 77-100.

Davis, Allison, (1944), Socialisation and adolescent personality, In Adolescence, Yearbook of the National Society for the Study of Education, Vol. 43, Part. 1.

Debold, Elizabeth, (1995), Helping Girls Survive the Middle Grades, Principal, 74 (3, January), 23.

Dun, E. W (1975), Gazetteer of Manipur (fourth edition), Vivek publishing Company, New Delhi.

Economic Survey Manipur, (2005-06), Directorate of Economics and Statistics, Government of Manipur.

Economic Survey Manipur, (2005-06). , op. cit.

Epidemiological Report, (2008), the Manipur State AIDS Control Society.

Femida Handy and Meenaz Kassam, (2004), Women's empowerment in rural India, Paper presented as the ISTR conference, Toronto Canada

Friedl, E, (1975), Women and Men: An Anthropological View, Holt, Rinehart & Winston, New York.

Gaitonde, I.R., (2001), A Thief in the Night: Understanding AIDS, Chennai: East West Books.

Gar, Suneela, Nandini Sharma and Ragini Sahay, (2001), Socio-Cultural Aspects of Menstruation in an urban Slum in Delhi, India, Reproductive Health Matters, 9 (17), 16-23.

Ge X, et. al., (1996), Coming of Age Too Early: Pubertal influences on Girls' Vulnerability to Psychological Distress, Child Development, 7, 3386-3400.

George, A, (1994), It Happens to us: Menstruation as Percieved by Poor Women in Bomba', In J. Gittelsohn, M. E. Bentley, P. J. Pelto, M. Nag, S. Pachauri, A. D Harrison and L. Landman (eds),'Listening to Women Talk About Their Health: Issues and Evidence from India, Ford Foundation and Har Anand, New Delhi, 168-83.

Ghosh, G. K, et. al., (1997), Women of Manipur, A.P.H. Publishing Corporation, New Delhi.

Golinko, B.E, (1984), Adolescence: Common Pathways through life, Adolescence, 19, 749-751.

Goodburn, Elizabeth. A and Ross, David. A, (1995), A Picture of Health: A Review and Annotated Bibliography of the Health of Young People in Developing Countries, Published by the World Health Organisation and UNICEF.

Govindasamy, P. and A. Malhotra (1996), Women's Position and Family Planning in Egypt, Studies in Family Planning 27 (6): 328-340.

Green, L.W, (1999), Health Education's Contributions to Public Health in the Twentieth Century: A Glimpse through Health Promotions Rear View Mirror, in Annual Review of Public Health, 20, 67-88.

Gupta, I. and Mitra, A., (1998), Knowledge of HIV/AIDS among Migrants in Delhi Slum, Working Paper: E/195/98, Institute of Economic Growth, New Delhi.

Hashemi Syed, Sydney Ruth Schuler and Ann Riley, (1996), Rural Credit Programs and Women's Empowerment in Bangladesh, World Development, Volume 24, No. 4: 635-653.

Hindin, M. J. (2000), Women's Power and Anthropometric Status in Zimbabwe. Social Science and Medicine 51:1517-1528.

Huffman, J. W, (1986), Teenagers' Gynaecological Problems, Medical Aspects of Human Sexuality, 20, 57-61.

Human Development Report, (2005), Oxford University Press, New Delhi, Published for the United Nations Development Programme (UNDP).

IDRC, (2006-05), India's Missing Daughters: An International Development Research Centre Publications. http://www.idrc.ca/en/ev-95719-201-1-DO_TOPIC.html

IIPS, (2000), National Family Health Survey, India 1998-99, IIPS, Mumbai.

Indian Council of Medical Research, ICMR, (1992), Task Force study on Field Supplementation, Trial in pregnant women with 60 MG, 120 MG and 180 MG of Iron with 500 G of Folic Acid, New Delhi, Indian Council of Medical Research.

International Institute of Population Sciences, IIPS (2000), National Family Health Survey (NFHS-2)1998-99, Mumbai: International Institute of Population Sciences.

International Institute of Population Sciences, IIPS, (2007), National Family Health Survey-3 (2005-06), Government of India, New Delhi, IIPS. http://mohfw.nic.in/nfhs3/installreader.htm

Jejeebhoy, S.J. (2000), Women's autonomy in rural India: Its dimensions, determinants and the influence of context., In H. Presser and G. Sen (Eds), Women's Empowerment and Demographic Processes: Beyond Cairo, New York: Oxford University Press.

Kabeer, N, (2001), Reflections on the Measurement of Women's Empowerment- Theory and Practice, in: Discussing women's empowerment-theory and practice, Stockholm, Novum Grafiska AB.

Karl, Marilee, (1995), Women and Empowerment: Participation and Decision Making, Zed Books Ltd. London and New Jersey.

Khan, M. E. and C. V. S. Prasad, (1983), Family Planning Practices in India- Second All- India Survey, Operations Research Group, Baroda.

Khanna, Anoop, R.S Goyal and Rahul Bhawsar, (2005), Menstrual Practices and Reproductive Problems: A study of Adolescent Girls in Rajasthan, Journal of Health Management, 7, 1, Sage Publications, New Delhi, Thousand Oaks, London, 91-107.

Kishor, S., (2000), Empowerment of Women in Egypt and Links to the Survival and Health of Their Infants, In Women's Empowerment and Demographic Processes: Moving Beyond Cairo. Harriet Presser and Gita Sen, (eds.) New York: Oxford University Press.

Laishram, Suresh, (2002), Health and the Status of Women in Manipur, Seminar on Manipur Women's Movement in the 20th cent. 26th and 27th March, 2002, Courtesy: The Imphal Free Press.

Malhotra, A and S Schuler, (2005), Women's Empowerment as a Variable in International Development, In Measuring Empowerment: Cross-Disciplinary Perspectives. 71–88. Narayan, D, (ed.), Washington DC: World Bank, Gender and Development Group.

Malhotra, A. and M. Mather., (1997), Do Schooling and Work Empower Women in Developing Countries? Gender and Domestic Decisions in Sri Lanka, Sociological Forum 12(4), p. 599-630.

Malladi Subbamma, (1985), Women, Tradition and Culture, Sterling Publishers Private Ltd. New Delhi, P-15.

Manipur AIDS Control Society, Annual Report, (2006-2007).

Mason, K. O, (2005), Measuring Women's Empowerment: Learning from Cross-National Research." P. 89-102 in Measuring Empowerment: Cross-Disciplinary Perspectives, Deepa Narayan (ed.) Washington, D.C.: The World Bank.

Midgley, J, (1995), Social development: The developmental perspective in social welfare. Thousand Oaks, CA: Sage.

Ministry of Human Resource Development (MHRD), (2003), National Youth Policy, 2003, Department of Youth Affairs and Sports, Government of India, New Delhi, MHRD. http://yas.nic.in/yasroot/policies/youth_policy_03.htm #NATIONAL (19.02.07).

Mira Shiva, (2001), Health Care in Last 50 years and Women's Empowerment, in Empowering the Indian Women, (Ed) Promilla Kapur, Publications Division, Ministry of Information and Broadcasting, Government of India.

Mittal, Suneeta, *et. al.*, (2003), Socio-Demographic profile of Emergency Contraceptive Users, Journal of Family Welfare, Vol. 49, No. 2, December.

Monkman, Karen, (1997), Training Women for Change and Empowerment, in Nelly Stromquist (ed.) Women in the Third World. Garland.

Murdock, G.P, (1949), Social Structure, Macmillan, New York.

NACO (not dated): Youth: What Makes Youth Vulnerable? Available at www.nacoonline.org/Quick_Links/Youth, accessed on October 4, 2007.

NACO, (2005), Rapid Needs Assessment of HIV Programme Needs in Five North Eastern States of India, A Joint Initiative of NACO, AusAID, UNAIDS.

Narayan, D, (2005), Measuring Empowerment: Cross-Disciplinary Perspectives, Washington DC: World Bank.

Oakly, A, (1974), Housewife, Allen Lane, London.

Pandey, J. Yadav, et. al., (1999), Adolescence Education in Schools: Package of Basis Materials, National Population Education Project, National Council of Educational Research and Training, New Delhi.

Pareto, V, (1926), Les Systems Socialistes, Marcel Giard, Paris, 2 vols.

Parsons, T, (1959), The Social Structure of the Family In the Family: Its Functions and Destiny, R. N. Anshen (ed.), Harper &Row, New York.

Patton, G. C, *et. al.*, (1996), Menarche and Onset of Depression and Anxiety in Victoria, Australia, Journal of Epidemiology and Community Health, 50 (6), 661-66.

Planning Commission, (2001), Report on the Working Group on Adolescents for the Tenth Five Year Plan, (2002-2007), Government of India, New Delhi. http://planningcommission.nic.in/aboutus/committee/wrkgrp/wg_adolcnts.pdf.

Planning Commission, (2004), Tenth Five Year Plan, (2002-2007), Chapter 2.11, Women and Children, Yojana Bhavan, Government of India, New Delhi.http://planningcommission.nic.in/plans/planrel/fiveyr/10th/volume2/v2_ch2_11.pdf

Planning Commission, (2004), Tenth Five Year Plan, (2002-2007). , op. cit.

Prasad, R.R, (2004), 'Participation and empowerment: Rhetoric and reality' in 'Rural Development through Women's participation and electronic Media' (Ed) Sawalia Bihari Verma, Shiv kumar Singh, Pointer Publishers, Jaipur.

Presser, H. and G. Sen, (2000), Women's empowerment and demographic processes: Moving beyond Cairo, New York: Oxford University Press.

Presser. H, (1997), Demography, Feminism and the Science-Policy Nexus, Population and Development Review 23: 295-333

Raju, S., (2007), India Social Development Report, Council for Social Development, Oxford University Press.

Rama, Rao.A, (1963), A Study on Menstruation in Adolescents, Journal of Indian Medical Association, 40 (1), 315-19.

Rice, F. Philip, (1990), The Adolescent Development, Relationships and Culture, (sixth edition), Allyn and Bacon, Boston, London, Sydney, Toronto, 162.

Sangh Mittra and Bachchan Kumar, (2004), Encyclopaedia of Women in S. Asia (In 8 Volumes) Vol-1 India, Kalpaz Pulblications Delhi, P-3.

Schoen, Cathy, *et. al.,* (1997), The Commonwealth Fund Survey of the Health of Adolescent Girls, The Commonwealth Fund, November.

Schultz, TP, (1993), Returns to women's schooling, In Women's Education in Developing Countries: Barriers, Benefits and Policy, Hill, EKaMA, (ed.) Baltimore: Johns Hopkins University Press.

Seth, Mira (2000), Women and Development: The Indian Experience, Sage Publications, New Delhi. Thousand Oaks, London, P-17.

Shesadri, Subadra, (1997), Epidemiology of Nutritional Anemia among Pregnant and Lactating Women, Adolescent Girls and Pre-School Children: Baroda: Maharaja Sayaji Rao University of Baroda.

Shills, E, (1975), Centre and Periphery, University of Chicago Press, Chicago.

Shukla, S, (2005), Working on Menstruation with Girls in Mumbai, India: Vacha Women's Resource Centre: EQUALS, (15) pp. 5.

Sidramshettar, S. C (2004), The Journal of Family Welfare, Vol. 59, No. 2, December 48-54.

Sohoni, N.K, (1995), The Burden of Girlhood: A Global Inquiry into the Status of Girls, Third Party Publishing Company, California.

Srivastva, S.P. (1998), (ed.), Development Debate: Critical Perspective, Jaipur: Rawat Publications, p. 74.

Stromquist, Nelly P, (1995), The Theoretical and Practical Bases for Empowerment, In Carolyn Medel-Anonuevo (ed.) Women, Education and Empowerment: Pathways Towards Autonomy, Report of the International Seminar held at UIE, Hamburg, 27 January – 2 February 1993. Paris: UNESCO.

Subbarao, Kalr, (1995), Social gains from female education, Economic Development and Cultural Change, 44(1).

Sureender, S. et al., (1997), Knowledge and Attitude of School Children about HIV/AIDS: Evidences from Rural Maharashtra, Indian Journal of Social Work, 58 (4):599-615.

Tanner, J. M, (1972), Sequence, Tempo and Individual Variation in Growth and Development of Boys and Girls Aged Twelve to Sixteen: Early Adolescence, (eds) J. Kegan and Robert Coles, New York, W.W. Norton and Co.

The Week, (2002), December 22: 28-30.

Timothy, R. and Rajan, S.I., (2004), Awareness and Knowledge about HIV/AIDS in India: Evidences from RCH Survey (1998-99) in Demography India, Vol. 33, No. 1: 61-83.

UNAIDS, (1999), Report on the Global HIV/AIDS Epidemic. Geneva.

UNDP, 1993, Human Development Report, New York, Oxford University Press, pp 21- 22.

United Nations Division for the Advancement of Women, (1995), Enabling Environment for the Empowerment of Adolescent Girls. www.uneca.org/eca_resources/Publications/

United Nations Population Information Network, Guidelines on Women's Empowerment, http://www.un.org/popin/unfpa/taskforce/guide/iatfwemp.gdl.html

Vaidya, R. A, *et. al.*, (1998), Menstrual Pattern and Growth of Schoolgirls in Mumbai, Journal of Family Welfare, 44 (1), 66- 72.

Visaria, L, (1993) Female autonomy and fertility behaviour: An exploration of Gujarat data. In Proceedings of International Population Conference of International Union for Scientific Study of Population, Montreal, Vol. 4, Liege, Belgium: IUSSP. 263-275.

Weber, M, (1978), Economy and Society, University of California Press, Berkeley.

WHO, (2005), Nutrition in adolescence –Issues and Challenges for the Health Sector, Issues in Adolescent Health and Development, (WHO discussion papers on adolescence). http://whqlibdoc.who.int/publications/2005/9241593660_eng.pdf

WHO, (2008), Tackling Social and Economic Determinants of Health through Women Empowerment, The SEWA Case Study. New Delhi, WHO.

WHO, UNFPA, UNICEF, (1995), Action for Adolescent Health, Towards a Common Agenda, Recommendations from a Joint Study Group. http://www.who.int/child-adolescent-health/New_publications/ADH/WHO _FRH_ADH_ 97.9_en.pdf (8.02.07).

Wichstrom, L, (1999), The Emergence of Gender Difference in Depressed Mood during Adolescence: the Role of Intensified Gender Socialisation, Development Psychology, 35, pp.232-45.

Women and Men in India, (2001), Central Statistical Organisation, Ministry of Statistics and Programme Implementation, Government of India.

World Bank, (2001), Engendering Development: Through Gender Equality in Rights, Resources, and Voice. World Bank Policy Research Report, Oxford: Oxford University Press.

APPENDIX - I
INTERVIEW SCHEDULE
(ADOLESCENT GIRLS)

1. Name:
2. Age:
3. Religion:
4. Educational Status:

   (a) Illiterate ☐ (b) Literate ☐
5. If literate, what is your educational qualification?

   .....
6. Do you yourself receive differential treatment from your parents?

   (a) Yes ☐ (b) No ☐
7. Do you help your mother in the household work?

   (a) Yes ☐ (b) No ☐
8. Does your brother help your mother in the household work?

   (a) Yes ☐ (b) No ☐
9. How old were you when you experienced your first monthly period (menstruation)?

   .....
10. Do you have any knowledge or were you aware about it?

    (a) Yes ☐ (b) No ☐
11. If yes, from where do you get information? .....
12. What was your reaction towards the first menstruation?

    (a) Suffer from mental stress ☐

    (b) Face no problem ☐
13. During your monthly period, what material do you use?

    (a) Market available sanitary pads/napkins ☐

    (b) Traditional made (cloth) ☐

14. During your menses, are you prohibited from performing certain religious rites?

(a) Yes ☐ (b) No ☐

15. Are you allowed to touch certain religious items, kitchenware, food etc.?

(a) Yes ☐ (b) No ☐

16. Do you suffer from mental stress because of such restrictions?

(a) Yes ☐ (b) No ☐

17. Do you suffer from any health problems during menstruation?

(a) Yes ☐ (b) No ☐

18. How do you get rid of the problems?

.....

19. Do you suffer from any mental stress because of it?

(a) Yes ☐ (b) No ☐

20. Are you given extra care in diet during those 5-6 days?

(a) Yes ☐ (b) No ☐

21. Are you aware of the various physical changes that take place during adolescence?

(a) Yes ☐ (b) No ☐

22. If yes, what/who is the main source of information?

.....

23. If no, do you suffer from any mental stress because of the physical changes?

(a) Yes ☐ (b) No ☐

24. Are you aware of the various available contraception, pregnancy and childbearing?

(a) Yes ☐ (b) No ☐

25. Are you aware of the highly rampant illness HIV/AIDS, RTIs, STDs etc.?

(a) Yes ☐ (b) No ☐

APPENDIX – II
INTERVIEW SCHEDULE
(WOMEN)

1. Name:
2. Age:
3. Religion:
4. Educational Status:

   (a) Illiterate ☐ (b) Literate ☐
5. If literate, what is your educational qualification?

   .....
6. Marital status:

   (a) Married ☐ (b) Divorce ☐

   (c) Widow ☐ (d) Separated ☐
7. Age at marriage: .....
8. Husbands' age at marriage: .....
9. With whose family are you staying at present?

   (a) With husbands' family ☐ (b) Parents' family ☐

   (c) Independent of the above ☐ (d) Rented house ☐
10. Family Size .....

Husbands' Background

11. Age in completed years .....
12. Educational status:

    (a) Illiterate ☐ (b) Literate ☐
13. If literate, what is your educational qualification?

    .....
14. Occupation:

    (a) Service ☐ (b) Agriculture ☐

    (c) Business ☐ (d) Wage Earner ☐ (e) Others ☐
15. Monthly Income:

(a) Below 1500 ☐ (b) 1500 – 3000 ☐

(c) 3000 – 4500 ☐ (d) Above 4500 ☐

16. How is your husband's nature?

(a) Good ☐ (b) Bad ☐

(c) Indifferent ☐

17. Your relation with your Husband:

(a) Understanding ☐ (b) Ill-treated ☐

(c) S0-so ☐

18. Is your husband addicted to drinking, prostitution, gambling etc.?

(a) Yes ☐ (b) No ☐

19. Do you think that husbands' brutality is a manly quality?

(a) Yes ☐ (b) No ☐

20. Does your husband apologized when he return in sense?

(a) Yes ☐ (b) No ☐

Economic profile

21. Aside from your household work, are you currently working outside?

(a) Yes ☐ (b) No ☐

22. If yes, what kind of work do you do? .....

23. Reasons for taking up employment:

(a) Own choice ☐ (b) Poverty ☐

(c) Husband's choice ☐ (d) Others ☐

24. What is your monthly income?

(a) Below 1500 ☐ (b) 1500 – 3000 ☐

(c) 3000 – 4500 ☐ (d) Above 4500 ☐

25. How much do you contribute to the family income?

(a) Almost none ☐ (b) Less than half ☐

(c) About half ☐ (d) More than half ☐

26. In your family who spends the family income? .....

27. Do you have freedom to spend your own income?

(a) Yes ☐ (b) No ☐

28. Are you dependent on the family for your economic needs?

(a) Fully ☐ (b) Partly ☐

(c) Not at all ☐

29. Are there any separate savings in your name?

(a) Yes ☐ (b) No ☐

Health Profile

30. During your monthly period, what material do you use?

(a) Market available sanitary pads/napkins ☐

(b) Traditional made (cloth) ☐

31. Are you suffering from any health (gynaecological) illness?

(a) Yes ☐ (b) No ☐

32. Are you still suffering from it?

(a) Yes ☐ (b) No ☐

33. If treated, from whom do you receive treatment?

(a) Government Doctor ☐ (b) Private Doctor ☐

(c) Priest ☐ (d) Others ☐

34. You consult a doctor on:

(a)Your own will ☐

(b) On consent of family members ☐

35. You consult a doctor:

(a) When illness is serious ☐ (b) For usual check-up ☐

36. During your pregnancy, did you go for antenatal check-up?

(a) Yes ☐ (b) No ☐

37. From where do you receive treatment?

(a) Public medical centre ☐ (b) Private ☐

38. Do you receive the service you want?

(a) Yes ☐ (b) No ☐

39. The condition of the health facility visited was:

(a) Not clean ☐ (b) Somewhat clean ☐

(c) Very clean ☐

40. Where do you give birth to a child?

(a) Government hospital ☐ (b) Private ☐

(c) Home ☐

41. Do you go for postnatal check-up?

(a) Yes ☐ (b) No ☐

Contraceptive Prevalence

42. Do you know the various available ways or methods that a couple can use to delay or avoid pregnancy?

(a) Yes ☐ (b) No ☐

43. Which ways or methods have you heard about?

.....

44. Have you ever used or tried any method in any way to delay or avoid pregnancy?

(a) Yes ☐ (b) No ☐

45. What methods have you used?

.....

46. Do you intend to use a method to delay or avoid pregnancy at any time in future?

(a) Yes ☐ (b) No ☐

47. If no, what is the main reason for not intending to use in future?

.....

48. According to you, what is the ideal interval between the births of the next child?

.....

49. Who decide on how many children you will have?

(a) Yourself ☐ (b) Husband ☐

(c) Both you and your husband ☐ (d) Family members ☐

50. In general, do you approve or disapprove of couples using a method to delay or avoid getting pregnant?

(a) Disapprove ☐ (b) Approve ☐

51. Do you think your husband approve the use of contraception?

(a) Disapprove ☐ (b) Approve ☐

(c) Do not know ☐

52. How often have you talked about family planning with your husband?

(a) Never ☐ (b) Once or twice ☐

(c) More often ☐

Decision – making profile

53. Do you select your life partner yourself?

(a) Yes ☐ (b) No ☐

54. Are you involved in making decisions on the following issues?

(a) Money matters ☐ (b) Children's education ☐

(c) Children's job ☐ (d) No decision of yours ☐

55. Do you need permission for going to?

(a) Market ☐ (b) Visit Parents & relatives ☐

(c) Movie ☐ (d) No need for permission ☐

56. Do you decide on what items to cook in the family?

(a) Yes ☐ (b) No ☐

57. Do you get time for social contact?

(a) Yes ☐ (b) No ☐

58. Can you take your children to a doctor without the consent of the head of the family?

(a) Never ☐ (b) Sometimes ☐

(c) Always ☐

59. Do you believe that diseases can be cured by offering to Gods and Goddesses?

(a) Don't ☐ (b) Only to some extent ☐

(c) Believe ☐

60. Have you ever heard of the illness HIV/AIDS, STDs, RTIs etc.?

(a) Yes ☐ (b) No ☐

61. Is there anything a person can do to avoid HIV/AIDS?

(a) Yes ☐ (b) No ☐

62. Are you aware of the various Governmental policies and programmes available from time to time?

(a) Yes ☐ (b) No ☐

63. Do you think you will need permission from family members if you wish to contest elections in future?

(a) Yes ☐ (b) No ☐

64. In your opinion, how much education should be given to girls these days?

.....

65. In your opinion, how much education should be given to boys these days?

.....